

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01117  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
01089

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md</u> c. LENGTH OF STAY IN ID <u>9 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pro George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> d. STREET ADDRESS <u>6207 Queens Chapel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irene</u> First <u>P. Adams</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH <u>Jan 15, 19 66</u> Month <u>Jan</u> Day <u>15</u> Year <u>19 66</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1911</u> 9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Cordie Cantwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>John C Campbell</u> Address <u>Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Rupture of malignant gastric ulcer</u> DUE TO (c) <u>Carcinoma of stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>1-15-66</u>	
ACTUAL SIGNATURE <u>John Kehoe, M.D., Riverdale</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 18, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Powell Valley</u>	23d. LOCATION (City, town or county) (State) <u>Big Stone Gap Virginia</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 18 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

011118

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01090

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>2527 Iverson Street</u>	
3. NAME OF DECEASED (Type or print) <u>Dawn Meshel AGRIESTI</u>		4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 July 1964</u>
9. AGE (In years lost birthday) Yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ronald M. Agriesti</u>		14. MOTHER'S MAIDEN NAME <u>Dyanne C. Cupp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ronald M. Agriesti</u>		Address <u>2527 Iverson Street</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent pleural effusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>And Bilateral lobar pneumonia</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>1-5-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u>		ADDRESS <u>4308 Suitland Rd Suitland Maryland</u>	
25a. REC'D BY REGISTRAR <u>JAN 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01000

01110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01119 CERTIFICATE OF DEATH 01091									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville Md			c. LENGTH OF STAY IN 1b 26 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			d. STREET ADDRESS 3706 Oliver Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3706 Oliver Street					d. STREET ADDRESS 3706 Oliver Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Tursie Lucille Allen					4. DATE OF DEATH Month Day Year Jan 14, 19 66				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 26, 1900		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Howard Lonas					14. MOTHER'S MAIDEN NAME Etta Sager				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Maxine Miller Hyattsville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 generalizel Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan 14, 1963, to Jan 14, 1966, that (I) (we) last saw the deceased alive on Jan 13, 1966, and that death occurred at 1:45 PM, from the causes and on the date stated above.									
22a. SIGNATURE W.H. Clements					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED JAN. 14, 1966		
22c. PHYSICIAN'S NAME (Type) W.H. CLEMENTS					22d. ADDRESS 6001 - 35 Ave Hyattsville, Md -				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery			23d. LOCATION (City, town or county) (State) Macanie Va.		
24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md					25a. REC'D BY REGISTRAR DATE JAN 18 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MEDICAL CERTIFICATION

10010

01110

THE FOLLOWING IS A SUMMARY OF THE RESULTS OF THE SURVEY CONDUCTED BY THE BUREAU OF THE LAND OFFICE, DEPARTMENT OF THE INTERIOR, DURING THE YEAR 1901.

1. The total area of land surveyed during the year was 1,234,567 acres.

2. The total area of land entered for sale was 567,890 acres.

3. The total area of land sold was 234,567 acres.

4. The total amount of money received from the sale of land was \$1,234,567.

5. The total amount of money expended for the survey was \$567,890.

6. The total amount of money received from the sale of land, after deducting the expenses of the survey, was \$666,677.

7. The total amount of money received from the sale of land, after deducting the expenses of the survey, was \$666,677.

8. The total amount of money received from the sale of land, after deducting the expenses of the survey, was \$666,677.

9. The total amount of money received from the sale of land, after deducting the expenses of the survey, was \$666,677.

10. The total amount of money received from the sale of land, after deducting the expenses of the survey, was \$666,677.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01120		Item 14 Film G372 274/66 mh				01092					
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3203 Ramblewood Drive					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights d. STREET ADDRESS 3203 Ramblewood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Laura Middle M Last Allers		4. DATE OF DEATH Month January Day 5 Year 1966									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-17		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assoc. Interstate Comm Prac.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Pfeiffer					14. MOTHER'S MAIDEN NAME Margaret A. <del>Byrd</del> Murk						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Norman C. Allers 3202 Ramblewood Drive						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1930 Metastatic carcinoma DUE TO (b) Carcinoma of brain DUE TO (c) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 6 months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May 21, 1965, to 1-5, 1966, that (I) (we) last saw the deceased alive on 1-4, 1965, and that death occurred at PM, from the causes and on the date stated above.											
22a. SIGNATURE Thos F Cleary					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-6-66				
22c. PHYSICIAN'S NAME (Type) Thos. F. Cleary M.D.					22d. ADDRESS 3611-Branch Ave SE, Wash DC 20023						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-8-66		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City, town or county) (State) Baltimore Maryland				
24. FUNERAL DIRECTOR ADDRESS Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland					25a. REC'D BY REGISTRAR DATE JAN 11 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge				

01100

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FOR STATE  
HEALTH DEPT.

01121

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01093

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>4 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b> 16-1		d. STREET ADDRESS <b>2503 Keating Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rose</b> First <b>M.</b> Middle <b>Alley</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>24 June 1928</b>
9. AGE (In years lost birth day) yrs. <b>37</b>		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sec'try</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Henery</b>		14. MOTHER'S MAIDEN NAME <b>Egbert, Rose C.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>mother</b>		Address <b>2503 Keating Hillcrest Hgt, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> <b>9705</b> DUE TO <b>Cirrhosis of liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>xxx and acute intoxication (salicylates)</b> (c) <b>4 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>unknown</b> <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Took overdose of salicylates.</b>	
20c. TIME OF INJURY Month, Day, Year <b>? 1/10 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>1-16-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Md</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>	
ADDRESS <b>Washington, D. C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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01122

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01094

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Stephen Anderson</u>		4. DATE OF DEATH <u>1</u> <u>21</u> <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Feb. 1910</u>
9. AGE (In years last birthday) <u>55</u> YRS.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert G. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Hel lmuth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Dorothy M. Anderson (above</u>		Address <u>(Wife) address)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4/4X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>From Valvular rheumatic heart disease</u> DUE TO (c) <u>over 20 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - over 10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-21-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/24/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25. REC'D BY REGISTRAR <u>JAN 26 1966</u>	
ADDRESS <u>Mt. Rainier Maryland</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
01122					01095					
1. PLACE OF DEATH a. COUNTY Prince George's					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b 10-1/2 hrs.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS College Park					
3. NAME OF DECEASED (Type or print) Grace B. Baggott					4. DATE OF DEATH January 12 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 23, 1892		9. AGE (In years last birthday) 73 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel E. Baker					14. MOTHER'S MAIDEN NAME Mary E. Evey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT James W. Baggott - son - 2014 Rockland Ave.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 12 hrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from Jan. 11, 1966, to Jan. 12, 1966, that (X) (we) last saw the deceased alive on Jan. 12, 1966, and that death occurred at 9:00 M, from the causes and on the date stated above.										
22a. SIGNATURE William D. Rosson					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 1/12/66		
22c. PHYSICIAN'S NAME (Type) William D. Rosson, M.D.					22d. ADDRESS 5701 85th Ave Hyattsville					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland, Prince Geo. Md.				
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home					ADDRESS 1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR JAN 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE  
HEALTH DEPT

01124

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01096

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>116 49th. Street, N.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Esther Arvilla Bailey</b>		4. DATE OF DEATH Month <b>1</b> Day <b>1</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-15-1936</b>
9. AGE (In years lost birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Nashville, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard Ewing</b>		14. MOTHER'S MAIDEN NAME <b>Ester Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>512-40-0897</b>	
17. INFORMANT <b>Delmar O. Bailey, 116 - 49th St. N.E. Wash D.C.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>981X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by assailant alongside Kenilworth Interchange.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>5:00pm</b> p.m. <b>1-1-</b> 19 <b>66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Kenilworth Ave., near Tuxedo Road, Prince</b>		20f. (City or town) (County) (State) <b>George County, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>1-2-65</b>	
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 6, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Ft. Myer, Virginia</b>	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., INC. Washington, D. C.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 7 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01125 CERTIFICATE OF DEATH 01097											
1. PLACE OF DEATH a. COUNTY <b>Pr. George's Co.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Temple Hills Maryland</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6466- Portal Ave., S. E.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's Co.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Temple Hills, Maryland 16-1</b> d. STREET ADDRESS <b>6466- Portal Ave., SE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Patrick J. Baker</b>			First Middle Last			4. DATE OF DEATH <b>January 21st 1966</b>			Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 20- 1899</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Yard</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ireland.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Peter Baker</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Sherlock</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Edna M. Baker ( Wife ) Same as # 2.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAC INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTHERIO SCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>5 YEARS</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7/14</b> , 19 <b>60</b> to <b>1/21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/21</b> , 19 <b>66</b> , and that death occurred at <b>0455M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Bruno Koleca</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/21/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>BRUNO KOLECA</b>						22d. ADDRESS <b>4400 STAMP RD. MARLOW HEIGHTS - MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Jan. 24- 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR <b>Simmons Bros</b>						ADDRESS <b>Simmons Bros</b>		25a. REC'D BY REGISTRAR <b>IAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros</b>						ADDRESS <b>Simmons Bros</b>		25a. REC'D BY REGISTRAR <b>IAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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**Figure 1**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01126

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01098

Item 14, Film G 374 3/1/66

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>3 yr., 6 mo., 4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47-3</b> d. STREET ADDRESS <b>616 9th Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Josephine</b> Middle <b>Barber</b> Last <b>Barber</b>				4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/1902</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>6</b>		IF UNDER 24 HRS. Days <b>4</b>		Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>unknown</b>			
14. MOTHER'S MAIDEN NAME <b>unknown Cornelia Ross</b>				15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <b>unknown</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>				17. INFORMANT <b>unknown</b> Address <b>unknown</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Partial intestinal obstruction, probably secondary to adhesions from previous abdominal surgery (hysterectomy, remote)</b> DUE TO (b) <b>Recurrent cerebrovascular accidents, bilateral with global aphasia</b> DUE TO (c) <b>Diabetes mellitus; chronic urinary tract infection; decubiti with osteomyelitis, left heel</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; chronic urinary tract infection; decubiti with osteomyelitis, left heel</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <input type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>7/25</b> , 19 <b>62</b> , to <b>1/29</b> , 19 <b>66</b> , that <del>it</del> (we) last saw the deceased alive on <b>1/29</b> , 19 <b>66</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>				22b. DATE SIGNED <b>1/29/66</b> 22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-3-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat.</b>		23d. LOCATION (City, town or county) (State) <b>Glenn Dale, Md.</b>	
24. FUNERAL DIRECTOR <b>Johann + Johnson</b> <b>4804 Eda. Ave. N.W.</b>				25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01130

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\* cholelithiasis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington,</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 15 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington,</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>						d. STREET ADDRESS <b>4503 15th Street, N. W.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucille</b> Middle <b>Loid</b> Last <b>Barnett</b>			4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>1966</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/17/1890</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>King George, Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Beverly White</b>						14. MOTHER'S MAIDEN NAME <b>Caroline Harris</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-28-0445</b>		17. INFORMANT <b>Decedent</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>4221</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(associated with pulmonary embolism, rt. upper lobe)</b> DUE TO <b>lobe</b> (c) <b>Arteriosclerotic cardiovascular disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; pulmonary tuberculosis; amputation left leg due to diabetic gangrene; myocardial infarction, old; cholecystitis and *</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>002.1</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>12/16</b> , 19 <b>65</b> , to <b>1/31</b> , 19 <b>66</b> , that <del>he</del> (we) last saw the deceased alive on <b>1/31</b> , 19 <b>66</b> , and that death occurred at <b>4:16 A.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Moe Weiss</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/31/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>						22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL PARK</b>		23d. LOCATION (City, town or county) (State) <b>PRINCE GEORGES, MD.</b>			
24. FUNERAL DIRECTOR <b>John T. Harris</b>						25a. REC'D BY REGISTRAR <b>John T. Harris</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1987

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

01128

01100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>437 M Street, N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>L.</u> Last <u>Bazemore</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Oct. 1931</u>
9. AGE (In years lost birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months <u>34</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>FITZHUGH</u>		14. MOTHER'S MAIDEN NAME <u>BAZEMORE ARLETHA THOMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>LORAINE BAZEMORE - SAME</u>	
17. INFORMANT Address <u>LORAINE BAZEMORE - SAME</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO <u>8164</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>From multiple skull fractures</u> DUE TO <u>min.</u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger of car involved in head-on collision.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4:00pm</u> p.m. <u>1-2-</u> 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 301 at Prince George County Line.</u>		20f. (City or town) (County) (State) <u>Weldon, N.C.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-4-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county) <u>1-4-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-6-66</u>	23b. DATE THEREOF <u>1-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WELDON, N.C.</u>	23d. LOCATION (City or Town) (County) (State) <u>WELDON, N.C.</u>
24. FUNERAL DIRECTOR <u>Frazier's Funeral Home, Inc. - WASH, D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 7 1966</u>	
ADDRESS <u>Frazier's Funeral Home, Inc. - WASH, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00110

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01129

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01101

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 16-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home Same as #2</b>		d. STREET ADDRESS <b>8331 12th Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Yetta</b> Middle <b>Berger</b> Last <b>Berger</b>		4. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>1965</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (month) <b>unknown</b> 1890 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.P.</b>	
13. FATHER'S NAME <b>PAUL MOSKOWITZ</b>		14. MOTHER'S MAIDEN NAME <b>SARAH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT (SON) <b>HENRY R. BERGER</b>		Address <b>3550 TUNLARD Rd. N.W. WASH, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>  <b>Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22. DATE SIGNED <b>1-16-65</b>
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ELESNAUGHTON CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D.C.</b>
24. FUNERAL DIRECTOR <b>Bernard Damjanovitch &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>3501 14th St. NW WASH, D.C.</b> 25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b> DATE <b>JAN 20 1966</b>	

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DATE OF ISSUE FOR REVENUE PURPOSES

REVENUE PURPOSES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01130		01102	
1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Charles	
c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anne G Berry		4. DATE OF DEATH Month Day Year January 24 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1870	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (County & State, or foreign country) Bryantown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Montgomery		14. MOTHER'S MAIDEN NAME Anne Jane Gilmore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. David Edelen		Address 3220 Connecticut Ave Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4200 DUE TO Arteriosclerotic Heart Disease (b) pneumonia DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks One week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Dehydration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-10, 1966, to 1-24, 1966, that (I) (we) last saw the deceased alive on 1-24, 1966, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE D. Sahakyan		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D. SAHAKYAN		22d. ADDRESS 5813 LANDOVER Rd. Chevy Chase	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 28, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION (City, town or county) (State) Piscataway, Md.	
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR FEB 1 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

61175

George George H

George

10 days

George's General Hospital

Ann

Berry

Female White

June 2, 1910



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02637

01131

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN lb <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> <u>16-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>Rt. 2, Box 318-A Dyson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William G. Oode Bond, Sr.</u>				4. DATE OF DEATH Month Day Year <u>1 26 19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 Jan. 1910</u> 55 yrs.	
9. AGE (In years last birthday) <u>55</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employed Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Detective Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John Bond</u>			
14. MOTHER'S MAIDEN NAME <u>Ruth Goode</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Irene Bond</u> Same as Address Item #2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>over 11 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kenoe</u> M.D.				22. DATE SIGNED <u>1-27-66</u>			
EXAMINER'S NAME (Type) <u>John Kenoe, M.D. Riverdale, Md.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Waldorf Md.</u>	
24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

16980

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01132

## CERTIFICATE OF DEATH

81103

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Pr Geo</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bellpoint</i> c. LENGTH OF STAY IN 1b <i>18 mos</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>ELEVEN CEDARS HOME</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Pr Geo</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>College Park</i> d. STREET ADDRESS <i>4717 Tecumseh street</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <i>MICHAEL</i> Middle <i>NMI</i> Last <i>BOSMA</i>				<b>4. DATE OF DEATH</b> Month <i>JAN</i> Day <i>22</i> Year <i>1966</i>													
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>White</i>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>Feb 14, 1878</i>		<b>9. AGE</b> (In years last birthday) <i>87</i> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Inspector Retired</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Cousin - Ind.</i>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Holland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>							
<b>13. FATHER'S NAME</b> <i>Jelle Bosma</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Leertje De Boer</i>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i>									
<b>16. SOCIAL SECURITY NO.</b> <i>2N-204184</i>				<b>17. INFORMANT</b> <i>T.B. BOSMA</i>				<b>18. ADDRESS</b> <i>4717 Tecumseh St. College Park, Md.</i>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial failure</i> DUE TO (b) <i>Generalized Arterio-sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 yr +</i>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)										<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <i>19</i> p.m.			<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)										
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>1964</i> <b>to</b> <i>Jan 10</i> <b>19</b> <i>66</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Jan 10</i> <b>19</b> <i>66</i> , <b>and that death occurred at</b> <i>7:30</i> <b>P.M.</b> <b>from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <i>W.K. Etienne</i>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <i>1-22-66</i>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <i>W.K. ETIENNE</i>						<b>22d. ADDRESS</b> <i>College Park Md.</i>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>			<b>23b. DATE THEREOF</b> <i>Jan 25, 1966</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Mt Olivet Cemetery</i>			<b>23d. LOCATION (City, town or county)</b> (State) <i>Washington D. C.</i>									
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <i>F. Gasch's Sons</i>						<b>ADDRESS</b> <i>Hyattsville, Maryland.</i>			<b>25a. REC'D BY REGISTRAR</b> <i>Jan 25 1966</i>								
<b>25b. REGISTRAR'S SIGNATURE</b> <i>John L. Judge</i>																	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01103

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VR A15 (4)  
20M 1/65

1 (M)

01133

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01104

1. PLACE OF DEATH a. COUNTY <i>Prince Georges Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>PRINCE GEORGE</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>CLINTON</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Aquasco, Md. 16-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Southern Md. Medical Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MAUDE Gibbons Brady</i>		4. DATE OF DEATH Month Day Year <i>JANUARY 30 1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 20, 1879</i>
9. AGE (In years last birthday) <i>86</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWORK</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWORK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>PRINCE GEORGE MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>JOHN R. GIBBONS</i>		14. MOTHER'S MAIDEN NAME <i>RICHARDSON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-36-7304</i>	
17. INFORMANT <i>Rt. Rev. W. H. BRADY</i>		Address <i>Box 149 DULAC WISCONSIN</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>309X Congestive heart failure</i> DUE TO (b) <i>dehydration</i> DUE TO (c) <i>Chronic Brain Synclum.</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Alfred R. Lapin</i>		22b. DATE SIGNED <i>1-31-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN</i>		22d. ADDRESS <i>CLINTON, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>2-3-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>ST. MARY'S</i>		23d. LOCATION (City, town or county) (State) <i>AQUASCO MD</i>	
24. FUNERAL DIRECTOR <i>The South Funeral Home, Waldorf, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>FEB 7 1966</i>	

01104

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01134

## CERTIFICATE OF DEATH

01105

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>6 Months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Arlington</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		d. STREET ADDRESS <b>1708 North Troy</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suitland Nursing Home, Inc.</b>															
3. NAME OF DECEASED (Type or print) <b>Annie Teresa Brashears</b>				First Middle Last				4. DATE OF DEATH <b>January 17, 1966</b>				Month Day Year			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/5/1889</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Patrick Gateley</b>								14. MOTHER'S MAIDEN NAME <b>Elizabeth Kernan</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Catherine Brashears</b>				Address <b>1708 N. Troy St. Arlington, Virginia</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4721</b> DUE TO <b>Cardiovascular collapse</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1965</b> to <b>17 Jan, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 17, 1966</b> , and that death occurred at <b>3:40 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>John F. Shay</b>								22b. DATE SIGNED <b>1/17/66</b>				22c. PHYSICIAN'S NAME (Type) <b>John Shay, M.D.</b>			
22d. ADDRESS <b>5203 Silver Hill Rd., Suitland, Maryland</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 20-1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>				23d. LOCATION (city, town or county) (State) <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>								ADDRESS <b>1661- Gd. Hope Rd. SE. Wash., DC</b>				25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>			
								25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01135 CERTIFICATE OF DEATH 01106

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>45 02 Sheridan St.</b>			
3. NAME OF DECEASED (Type or print) <b>Leroy</b>		First <b>Schaeffer</b> Middle <b>Bremerman</b> Last		4. DATE OF DEATH <b>January 29 1966</b>		9. AGE (In years last birthday) <b>54</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Superior Mill Works</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel P. Bremerman</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-7450</b>		17. INFORMANT <b>Mr. John L. Hoover,</b>		Address <b>7907 Candlewood Dr. N. Alex., Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden bilateral pulmonary edema</b> 4201 DUE TO <b>Recent Endarterectomy &amp; aorto-femoral by pass graft</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>for arteriosclerosis Obliterans</b> DUE TO <b>Cardiac Hypertrophy with severe arteriosclerosis of Arteries</b> (c) <b>surrounding coronary arteries</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/14</b> , 19 <b>66</b> , to <b>1/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/29/66</b> 19 <b>66</b> and that death occurred at <b>4:45 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William A. Holbrook</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM A. HOLBROOK, M.D.</b>				22d. ADDRESS <b>6096 Pineway, University Pk., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 1, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg, Md.</b>	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Md.</b>				25a. REC'D BY REGISTRAR <b>FFB 4</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

<p align="center"><b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p>														
<p><b>1. PLACE OF DEATH</b>  a. COUNTY <b>Prince George</b>  b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b></p>						<p><b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)  a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Temple Hills</b>  d. STREET ADDRESS <b>5361 Canterbury Lane,</b>  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								
<p><b>3. NAME OF DECEASED</b>  (Type or print) <b>Edward Ellsworth Brightwell, Jr.</b></p>			<p><b>4. DATE OF DEATH</b>  Month <b>1</b> Day <b>31</b> Year <b>1966</b></p>			<p><b>5. SEX</b>  <b>M</b></p>			<p><b>6. COLOR OR RACE</b>  <b>W</b></p>			<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		
<p><b>8. DATE OF BIRTH</b>  <b>7 Sept., 1911</b></p>			<p><b>9. AGE</b> (In years last birthday) <b>54</b> yrs.</p>			<p><b>10. IF UNDER 1 YEAR</b>  Months <b>1</b> Days <b>31</b></p>			<p><b>11. IF UNDER 24 HRS.</b>  Hours <b>19</b> Min. <b>66</b></p>					
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <b>Empl'd Auto Mechanic</b></p>						<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b>  <b>Auto Repair Business</b></p>								
<p><b>11. BIRTHPLACE</b> (State or foreign country)  <b>Washington, D. C.</b></p>						<p><b>12. CITIZEN OF WHAT COUNTRY?</b>  <b>U. S. A.</b></p>								
<p><b>13. FATHER'S NAME</b>  <b>Shelby Fillmore Brightwell</b></p>						<p><b>14. MOTHER'S MAIDEN NAME</b>  <b>Mary Gertrude Padgett</b></p>								
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b>  (Yes, no, or unknown) <b>Unknown</b></p>						<p><b>16. SOCIAL SECURITY NO.</b>  <b>---</b></p>								
<p><b>17. INFORMANT</b>  <b>Gladys Louise Brightwell</b></p>						<p><b>Address</b> <b>5361 Canterbury Way Temple Hills, Md.</b></p>								
<p><b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]</p>														
<p><b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b>  <b>4200 Heart failure</b></p>														
<p><b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b></p>														
<p><b>(b) Arteriosclerotic heart disease</b></p>														
<p><b>(c) Unknown</b></p>														
<p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b></p>														
<p><b>19. WAS AUTOPSY PERFORMED?</b>  YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>														
<p><b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b></p>														
<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)</p>														
<p><b>20c. TIME OF INJURY</b>  Month, Day, Year <b>19</b>  Hour a.m. <b>19</b> p.m. <b>19</b></p>				<p><b>20d. INJURY OCCURRED</b>  While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>				<p><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)</p>						
<p><b>20f. (City or town)</b>  <b>Upper Marlboro Md.</b></p>				<p><b>(County)</b></p>				<p><b>(State)</b></p>						
<p><b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b>  Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>														
<p><b>ACTUAL SIGNATURE</b> <i>John Kehoe</i> <b>EXAMINER'S NAME (Type)</b> <b>John Kehoe, M.D.</b>  <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>  <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>  <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>  <b>DATE SIGNED</b> <b>131-66</b>  <b>Address (Street, city, town, or county)</b> <b>Riverdale</b></p>														
<p><b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>  <b>Burial</b></p>				<p><b>22b. DATE THEREOF</b>  <b>2/4/66</b></p>				<p><b>22c. NAME OF CEMETERY OR CREMATORY</b>  <b>Trinity Cemetery</b></p>						
<p><b>22d. LOCATION (City, town, or county)</b>  <b>Upper Marlboro Md.</b></p>				<p><b>(State)</b></p>				<p><b>24a. REC'D BY REGISTRAR</b>  <b>FEB 8 1966</b></p>						
<p><b>23. FUNERAL DIRECTOR</b>  <b>Ritchie Bros. Upper Marlboro, Md.</b></p>				<p><b>24b. REGISTRAR'S SIGNATURE</b>  <i>Charles Judge</i></p>				<p><b>24c. REGISTRAR'S SIGNATURE</b></p>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01137 CERTIFICATE OF DEATH 01107

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Naylor</b> d. STREET ADDRESS <b>Rt. 1, Box 124</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby</b> First Middle Last <b>Brown</b>		4. DATE OF DEATH Month Day Year <b>January 5 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1965</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lucille Mable</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. ---	
17. INFORMANT <b>John Edward Brown</b>		Address <b>NAYLOR, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> <b>578X</b> DUE TO <b>Generalized peritonitis</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Perforation of the jejunum, spontaneous</b> DUE TO <b>cause undertermined (12 days, post-operative status)</b> (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 22</b> , 19 <b>65</b> to <b>Jan. 5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Jan. 5</b> , 19 <b>66</b> , and that death occurred at <b>10:15</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernardo Alvarado</b>		22b. DATE SIGNED <b>1/7/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M.D.</b>		22d. ADDRESS <b>6201 Riverdale Rd., Riverdale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 8 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>	23d. LOCATION (City, town or county) (State) <b>Waldorf Md.</b>
24. FUNERAL DIRECTOR <b>Hunt Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Waldorf Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>JAN 10 1966</b>			

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Prince George's General Hospital  
17.1. Box 126

Male  
John  
Boy  
Baby  
Brown  
Dec. 23. 1955

Prince George's, Maryland, USA

John E. Brown  
no

Generalized peritonitis  
Operation of the abdomen, appendectomy  
Cause undetermined (12 hr. post-operative status)

Jan. 2. 1956  
10:15  
see 17/56

Barnardo Riverside, N.I.  
8201 Riverside Rd., Riverside, Maryland



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

01138

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01108

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clinton Medical Center</b>		d. STREET ADDRESS <b>Rt. 1, Box 388</b>	
3. NAME OF DECEASED (Type or print) <b>Jacqueline Antoinette Brown</b>		4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12-10-1965</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Nebbie Brown-Brandywine MD</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>7630</b> IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-3-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-4-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Peter's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Waldorf Charles MD</b>
24. FUNERAL DIRECTOR <b>Marcell Adams Aguiar, Inc</b>		25a. REC'D BY REGISTRAR <b>DATE 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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THE UNIVERSITY OF CHICAGO  
LIBRARY

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Handwritten notes in cursive script, including the word "Handwritten" and "10110".

Handwritten notes at the bottom of the page, including the word "SUM" and "10110".



FOR STATE  
HEALTH DEPT

01139

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01109

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>4412 Ferndale Place</u>	
3. NAME OF DECEASED (Type or print) <u>Lytle Brown Jr.</u>		4. DATE OF DEATH <u>11 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Nov. 1906</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Point, New York</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Maj. Gen. Lytle Brown Sr</u>		14. MOTHER'S MAIDEN NAME <u>Louise L. Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wife</u> Address <u>Viola H. Brown Same as Item #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head with a .22 Cal. rifle</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1 to 5 PM 1-11-1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Basement of home</u>		20f. (City or town) <u>Same as #2</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-12-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 14-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS <u>Simmons Bros. 1661-Good Hope Rd SE Wash DC</u>		25a. REC'D BY REGISTRAR <u>JAN 17 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John Kehoe</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01140					01110				
Item #0 Film #312 1/17/66 pc									
1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pr. George General</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manlow Hgts.</u> d. STREET ADDRESS <u>6019 28th Ave.</u>				
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Harry</u> Last <u>Buscher</u>					4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1887</u> <u>July 8, 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Buscher</u>					14. MOTHER'S MAIDEN NAME <u>Tillie Walsh</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>577-70-0000</u>		17. INFORMANT <u>Mary M. Buscher, Same as #2</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>4201</u> DUE TO (b) <u>arteriosclerotic cardiovascular dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>14th</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-15-1966</u> to <u>1-9-1966</u> , that (I) (we) last saw the deceased alive on <u>1-8-1966</u> , and that death occurred at <u>1:30</u> AM, from the causes and on the date stated above.								22b. DATE SIGNED	
22a. SIGNATURE <u>Richard Gitter</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. ADDRESS <u>656 East Cap St. Wash, D.C.</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD GITTER</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Jan. 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Pr. Geo. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Inc</u>				ADDRESS <u>517-11th St SE Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

01110

01110

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "JAN 1961" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

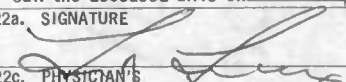
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

011141

011111

1. PLACE OF DEATH a. COUNTY <b>PG</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>PG</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs 15-2</b> d. STREET ADDRESS <b>118 13 College View Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Katherine M. Cahillane</b>		4. DATE OF DEATH Month <b>1</b> Day <b>6</b> Year <b>19 66</b>		5. SEX <b>f</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/6/1883</b>		9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>15</b> Days <b>2</b>		IF UNDER 24 HRS. Hours <b>15</b> Min. <b>2</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Michael O'Brien</b>								14. MOTHER'S MAIDEN NAME <b>Margaret Fitzgerald</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>				17. INFORMANT <b>Mr. Michael J. O'Brien</b> Address <b>(above address)</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart Failure</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>(Nephew)</b>												INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 hrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1966/12/6</b> , 19 <b>16</b> , to <b>1/6/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> 19 <b>67</b> , and that death occurred at <b>9:00 PM</b> from the causes and on the date stated above.																			
22a. SIGNATURE 								22b. DATE SIGNED <b>Dec. 7, 1966</b>				22c. PHYSICIAN'S NAME (Type) <b>Leon Levitsky, M.D.</b>				22d. ADDRESS <b>3408 Rhode Island Ave. Mt. Rainier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/12/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Springfield, Mass</b>							
24. FUNERAL DIRECTOR <b>Home Inc.</b>				25a. REC'D BY REGISTRAR <b>Nalley's Funeral</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE <b>JAN 12 1966</b>							

63226

725.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01142 Item 3 Film G CERTIFICATE OF DEATH 01112									
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 da. 12 hr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Palmer Park d. STREET ADDRESS 8345 Annendale Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Baby Glenn Boy Ray Campbell					4. DATE OF DEATH Month Day Year January 5 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 3, 1966		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 1 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Prince George, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray E. Campbell					14. MOTHER'S MAIDEN NAME Judy Marie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. --		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A theletasis, bilateral DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from birth, 19, to, 19, that (I) (we) last saw the deceased alive on 1-4 1965, and that death occurred at 2:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE Miles A. Jansa, M.D.					22b. DATE SIGNED 1-6-66				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS 7403 Varnum St. Landover Hills, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 1/22/66		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hosp.		23d. LOCATION (City, town or county) (State) Cheverly, Maryland			
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator					25a. REC'D BY REGISTRAR JAN 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



01118

01118

Prison George's General Hospital  
Chester  
Prison George's General Hospital  
Chester

White  
Baby  
Prison George's General Hospital  
Chester

Judy Harris  
Prison George's General Hospital  
Chester

*Prisoner of War*  
*Prisoner of War*

*Prisoner of War*  
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1-6-62

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. CDUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> d. STREET ADDRESS <b>4604 Davis Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Edith M. Campbell</b>			4. DATE OF DEATH <b>January 27 1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>9/18/14</b>		9. AGE (In years last birthday) <b>51 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>OKLAHOMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>DEL CARMAN</b>					14. MOTHER'S MAIDEN NAME <b>IDA ROBERTSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MARY ELIZABETH CAMPBELL</b>		Address <b>SAME AS #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis, left internal capsule</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>January 26, 1966</b> , to <b>January 27 1966</b> , that <del>he</del> (we) last saw the deceased alive on <b>January 27 1966</b> , and that death occurred at <b>9:20M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Carolina Paredes Manlapaz, M.D.</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-28-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Carolina Paredes Manlapaz, MD</b>					22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN 31, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEM</b>		23d. LOCATION (City, town or county) (State) <b>SUITLAND MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W W Chambers Co.</b>					ADDRESS <b>Cleveland Ave. P.O. Md</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

01113

Prince George's

Island

Prince George's

Island

Island

Island

Island

January 27

January 27

January 27

January 27

Female White

Housewife

Local (Barn)

No

Cardinal Throated, Left internal capsule

Cardinal Throated, Left internal capsule

January 27

January 27

Cardinal Throated, Left internal capsule

Cardinal Throated, Left internal capsule

Cardinal Throated, Left internal capsule

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT. **M**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clinton Medical Center</b>		d. STREET ADDRESS <b>4604 Davis Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Matthew A Campbell</b>		4. DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-1916</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Appliances</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Olie M. Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Sutphin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>579-09-5773</b>	
17. INFORMANT <b>Edith M. Campbell, Ave., Suitland, Md.</b>		Address <b>4605 Davis</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4200</b> (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-12-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, OR DISPOSAL <b>Burial</b>		23b. DATE THEREOF <b>Jan. 15, 1966</b>	
23c. NAME OF CEMETERY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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UNITED STATES OF AMERICA

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01115

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Air Force Base Hosp.</u>		d. STREET ADDRESS <u>7611 Woodland Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E</u> Last <u>Campbell Sr.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 June 1904</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>61</u> Days <u>10</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Mamie E. Sanford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. E. Campbell, jr</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of chest (.12 gauge shot gun)</u> 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Shot self in basement of home.</u> (c) <u>#2</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9:10am</u> p.m. <u>1-10-66</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Basement of home</u>		20f. (City or town) <u>#2</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>		22. DATE SIGNED <u>1-10-66</u>	
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/14/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wash. National</u>		23d. LOCATION (City or Town) <u>Suitland</u> (County) (State) <u>Md</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
300 4th st. N.E. Washington, D. C.		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

21116



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01146  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> <i>Magnolia Gardens</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington</i> b. COUNTY <i>DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>9104 Ford Luck Rd.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON, DISTRICT OF COLUMBIA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Lanham Md.</i>		d. STREET ADDRESS <i>1722 Douglas N.E.</i>	
3. NAME OF DECEASED (Type or print) <i>John Lee Cannon</i>		4. DATE OF DEATH <i>January 27 1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i>	8. DATE OF BIRTH <i>16 March 78 1897</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shop Foreman Railroad</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Henry Cannon</i>		14. MOTHER'S MAIDEN NAME <i>Patty Frances Waterman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>718-14-9815</i>	
17. INFORMANT <i>John N. Cannon</i>		Address <i>1722 Douglas N.E.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Right hemiplegia</i> DUE TO (c) <i>arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1-1</i> , 19 <i>66</i> to <i>27 Jan</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>27 January 1966</i> and that death occurred at <i>3:00</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas S. F. Mattingly</i>		22b. DATE SIGNED <i>27 Jan 66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas S. F. Mattingly M.D.</i>		22d. ADDRESS <i>2200 R.I. Ave N.E. DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>1/31/1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN CEMETERY</i>	23d. LOCATION (City, town or county) (State) <i>PRINCE GEORGES COUNTY, MD.</i>
24. FUNERAL DIRECTOR <i>Wesley Funeral Home - 1300 N. Street, N.W.</i>		25a. REC'D BY REGISTRAR <i>B 1</i>	
25b. REGISTRAR'S SIGNATURE <i>William M. Wyong - Washington, D.C.</i>		25c. DATE <i>1966</i>	

01110

01110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>MARYLAND</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>3324 13th St SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MICHAEL DONELL</b>			First Middle Last			4. DATE OF DEATH <b>JAN 12 1966</b>			Month Day Year		
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 JAN 66</b>		9. AGE (In years last birthday) <b>3</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, MD</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>JOHN THOMPSON CARR</b>						14. MOTHER'S MAIDEN NAME <b>CLEOLA (NMN) PRYOR</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Father Washington, D. C.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis &amp; respiratory failure</b> <b>7685</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Pneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9 AM</b> , 19 <b>66</b> , to <b>12 PM</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12 JAN 66</b> and that death occurred at <b>1:55 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Roger E. Spitzer</b>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>ROGER E. SPITZER</b>						22b. DATE SIGNED <b>1/12/66</b>					
22d. ADDRESS <b>USAF HOSPITAL ANDREWS AFB, MD</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON VA.</b>			
24. FUNERAL DIRECTOR <b>W W CHAMBERS 517 11th St SE</b>						25a. REC'D BY REGISTRAR <b>17 JAN 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

6-160486



FOR STATE  
HEALTH DEPT.

01148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01118

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>13 hours</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		d. STREET ADDRESS <b>7637 Chris Mar Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine E Carroll</b>		4. DATE OF DEATH <b>1 15 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-1925</b>
9. AGE (In years lost birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Penn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Reggie</b>	
14. MOTHER'S MAIDEN NAME <b>Glady's Riley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>19346-6910</b>		17. INFORMANT <b>Harold L. Carroll-Samson #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute barbiturate intoxication</b> <b>9702</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested overdose of barbiturate</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:00 p.m. 1/14 19 66</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Clinton P. G. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>1-16-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-19-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers &amp; Son, 517-11th St. S.E.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01149									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Run Hills			c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Run Hills 16-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4911- Dixon Street S.E.					d. STREET ADDRESS 4911- Dixon Street S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MERNA First M. Middle Last CLEMENS			4. DATE OF DEATH Jan. 19 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7-1896		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Nurse Aid		11. BIRTHPLACE (County & State, or foreign country) Nova Scotia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Byron McLeod					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Jewel M. Saverino			Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 260x DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.D. DUE TO (c) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH none	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1962, 19, to 1/19, 1966, that (I) (we) last saw the deceased alive on 1/15, 1966, and that death occurred at 10:35 AM, from the causes and on the date stated above.									
22a. SIGNATURE F. JOSEPH WEBER					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 22d. ADDRESS 1418 GOOD HOPE RD. S.E.		22b. DATE SIGNED 1/19/66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan. 22-1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery -		23d. LOCATION (City, town or county) (State) Patchogue, Long Island, N.Y.		
24. FUNERAL DIRECTOR Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC					25a. REC'D BY REGISTRAR JAN 21 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



011110

COMMUNICATE OF 011110

011110

1. The first part of the message is a header containing the date and time of the communication, followed by the name of the station and the name of the person to whom the message is addressed. The second part of the message is the body of the communication, which contains the main text of the message. The third part of the message is the footer, which contains the name of the person who sent the message and the name of the station.

PL 1/10

The following is a list of the names of the persons who sent the messages and the names of the stations to which the messages were sent. The names of the persons are listed in the first column, and the names of the stations are listed in the second column. The names of the persons are listed in the order in which the messages were received, and the names of the stations are listed in the order in which the messages were sent.

Name of Person	Name of Station
John Doe	Station A
Jane Smith	Station B
Bob Johnson	Station C
Alice Brown	Station D
Charlie White	Station E
Diana Green	Station F
Frank Black	Station G
Grace Hall	Station H
Henry King	Station I
Irene Lee	Station J
Jack Miller	Station K
Jill Wilson	Station L
Jim Taylor	Station M
Judy Adams	Station N
John Evans	Station O
Jane Harris	Station P
Bob Clark	Station Q
Alice Lewis	Station R
Charlie Walker	Station S
Diana Young	Station T
Frank Scott	Station U
Grace Baker	Station V
Henry Hill	Station W
Irene Green	Station X
Jack Adams	Station Y
Jill Baker	Station Z
Jim Carter	Station AA
Judy Evans	Station AB
John Foster	Station AC
Jane Gibson	Station AD
Bob Hall	Station AE
Alice King	Station AF
Charlie Lee	Station AG
Diana Miller	Station AH
Frank Nelson	Station AI
Grace Phillips	Station AJ
Henry Reed	Station AK
Irene Scott	Station AL
Jack Turner	Station AM
Jill Walker	Station AN
Jim Young	Station AO
Judy Ziegler	Station AP
John Baker	Station AQ
Jane Cooper	Station AR
Bob Evans	Station AS
Alice Foster	Station AT
Charlie Gibson	Station AU
Diana Hall	Station AV
Frank King	Station AW
Grace Lee	Station AX
Henry Miller	Station AY
Irene Nelson	Station AZ
Jack Phillips	Station BA
Jill Reed	Station BB
Jim Scott	Station BC
Judy Turner	Station BD
John Walker	Station BE
Jane Young	Station BF
Bob Ziegler	Station BG
Alice Adams	Station BH
Charlie Baker	Station BI
Diana Clark	Station BJ
Frank Evans	Station BK
Grace Foster	Station BL
Henry Gibson	Station BM
Irene Hall	Station BN
Jack King	Station BO
Jill Lee	Station BP
Jim Miller	Station BQ
Judy Nelson	Station BR
John Phillips	Station BS
Jane Reed	Station BT
Bob Scott	Station BU
Alice Turner	Station BV
Charlie Walker	Station BW
Diana Young	Station BX
Frank Ziegler	Station BY
Grace Adams	Station BZ
Henry Baker	Station CA
Irene Clark	Station CB
Jack Evans	Station CC
Jill Foster	Station CD
Jim Gibson	Station CE
Judy Hall	Station CF
John King	Station CG
Jane Lee	Station CH
Bob Miller	Station CI
Alice Nelson	Station CJ
Charlie Phillips	Station CK
Diana Reed	Station CL
Frank Scott	Station CM
Grace Turner	Station CN
Henry Walker	Station CO
Irene Young	Station CP
Jack Ziegler	Station CQ
Jill Adams	Station CR
Jim Baker	Station CS
Judy Clark	Station CT
John Evans	Station CU
Jane Foster	Station CV
Bob Gibson	Station CW
Alice Hall	Station CX
Charlie King	Station CY
Diana Lee	Station CZ
Frank Miller	Station DA
Grace Nelson	Station DB
Henry Phillips	Station DC
Irene Reed	Station DD
Jack Scott	Station DE
Jill Turner	Station DF
Jim Walker	Station DG
Judy Young	Station DH
John Ziegler	Station DI
Jane Adams	Station DJ
Bob Baker	Station DK
Alice Clark	Station DL
Charlie Evans	Station DM
Diana Foster	Station DN
Frank Gibson	Station DO
Grace Hall	Station DP
Henry King	Station DQ
Irene Lee	Station DR
Jack Miller	Station DS
Jill Nelson	Station DT
Jim Phillips	Station DU
Judy Reed	Station DV
John Scott	Station DW
Jane Turner	Station DX
Bob Walker	Station DY
Alice Young	Station DZ
Charlie Ziegler	Station EA
Diana Adams	Station EB
Frank Baker	Station EC
Grace Clark	Station ED
Henry Evans	Station EE
Irene Foster	Station EF
Jack Gibson	Station EG
Jill Hall	Station EH
Jim King	Station EI
Judy Lee	Station EJ
John Miller	Station EK
Jane Nelson	Station EL
Bob Phillips	Station EM
Alice Reed	Station EN
Charlie Scott	Station EO
Diana Turner	Station EP
Frank Walker	Station EQ
Grace Young	Station ER
Henry Ziegler	Station ES
Irene Adams	Station ET
Jack Baker	Station EU
Jill Clark	Station EV
Jim Evans	Station EW
Judy Foster	Station EX
John Gibson	Station EY
Jane Hall	Station EZ
Bob King	Station FA
Alice Lee	Station FB
Charlie Miller	Station FC
Diana Nelson	Station FD
Frank Phillips	Station FE
Grace Reed	Station FF
Henry Scott	Station FG
Irene Turner	Station FH
Jack Walker	Station FI
Jill Young	Station FJ
Jim Ziegler	Station FK
Judy Adams	Station FL
John Baker	Station FM
Jane Clark	Station FN
Bob Evans	Station FO
Alice Foster	Station FP
Charlie Gibson	Station FQ
Diana Hall	Station FR
Frank King	Station FS
Grace Lee	Station FT
Henry Miller	Station FU
Irene Nelson	Station FV
Jack Phillips	Station FW
Jill Reed	Station FX
Jim Scott	Station FY
Judy Turner	Station FZ
John Walker	Station GA
Jane Young	Station GB
Bob Ziegler	Station GC
Alice Adams	Station GD
Charlie Baker	Station GE
Diana Clark	Station GF
Frank Evans	Station GG
Grace Foster	Station GH
Henry Gibson	Station GI
Irene Hall	Station GJ
Jack King	Station GK
Jill Lee	Station GL
Jim Miller	Station GM
Judy Nelson	Station GN
John Phillips	Station GO
Jane Reed	Station GP
Bob Scott	Station GQ
Alice Turner	Station GR
Charlie Walker	Station GS
Diana Young	Station GT
Frank Ziegler	Station GU
Grace Adams	Station GV
Henry Baker	Station GW
Irene Clark	Station GX
Jack Evans	Station GY
Jill Foster	Station GZ
Jim Gibson	Station HA
Judy Hall	Station HB
John King	Station HC
Jane Lee	Station HD
Bob Miller	Station HE
Alice Nelson	Station HF
Charlie Phillips	Station HG
Diana Reed	Station HH
Frank Scott	Station HI
Grace Turner	Station HJ
Henry Walker	Station HK
Irene Young	Station HL
Jack Ziegler	Station HM
Jill Adams	Station HN
Jim Baker	Station HO
Judy Clark	Station HP
John Evans	Station HQ
Jane Foster	Station HR
Bob Gibson	Station HS
Alice Hall	Station HT
Charlie King	Station HU
Diana Lee	Station HV
Frank Miller	Station HW
Grace Nelson	Station HX
Henry Phillips	Station HY
Irene Reed	Station HZ
Jack Scott	Station IA
Jill Turner	Station IB
Jim Walker	Station IC
Judy Young	Station ID
John Ziegler	Station IE
Jane Adams	Station IF
Bob Baker	Station IG
Alice Clark	Station IH
Charlie Evans	Station II
Diana Foster	Station IJ
Frank Gibson	Station IK
Grace Hall	Station IL
Henry King	Station IM
Irene Lee	Station IN
Jack Miller	Station IO
Jill Nelson	Station IP
Jim Phillips	Station IQ
Judy Reed	Station IR
John Scott	Station IS
Jane Turner	Station IT
Bob Walker	Station IU
Alice Young	Station IV
Charlie Ziegler	Station IW
Diana Adams	Station IX
Frank Baker	Station IY
Grace Clark	Station IZ
Henry Evans	Station JA
Irene Foster	Station JB
Jack Gibson	Station JC
Jill Hall	Station JD
Jim King	Station JE
Judy Lee	Station JF
John Miller	Station JG
Jane Nelson	Station JH
Bob Phillips	Station JI
Alice Reed	Station JJ
Charlie Scott	Station JK
Diana Turner	Station JL
Frank Walker	Station JM
Grace Young	Station JN
Henry Ziegler	Station JO
Irene Adams	Station JP
Jack Baker	Station JQ
Jill Clark	Station JR
Jim Evans	Station JS
Judy Foster	Station JT
John Gibson	Station JU
Jane Hall	Station JV
Bob King	Station JW
Alice Lee	Station JX
Charlie Miller	Station JY
Diana Nelson	Station JZ
Frank Phillips	Station KA
Grace Reed	Station KB
Henry Scott	Station KC
Irene Turner	Station KD
Jack Walker	Station KE
Jill Young	Station KF
Jim Ziegler	Station KG
Judy Adams	Station KH
John Baker	Station KI
Jane Clark	Station KJ
Bob Evans	Station KK
Alice Foster	Station KL
Charlie Gibson	Station KM
Diana Hall	Station KN
Frank King	Station KO
Grace Lee	Station KP
Henry Miller	Station KQ
Irene Nelson	Station KR
Jack Phillips	Station KS
Jill Reed	Station KT
Jim Scott	Station KU
Judy Turner	Station KV
John Walker	Station KW
Jane Young	Station KX
Bob Ziegler	Station KY
Alice Adams	Station KZ
Charlie Baker	Station LA
Diana Clark	Station LB
Frank Evans	Station LC
Grace Foster	Station LD
Henry Gibson	Station LE
Irene Hall	Station LF
Jack King	Station LG
Jill Lee	Station LH
Jim Miller	Station LI
Judy Nelson	Station LJ
John Phillips	Station LK
Jane Reed	Station LL
Bob Scott	Station LM
Alice Turner	Station LN
Charlie Walker	Station LO
Diana Young	Station LP
Frank Ziegler	Station LQ
Grace Adams	Station LR
Henry Baker	Station LS
Irene Clark	Station LT
Jack Evans	Station LU
Jill Foster	Station LV
Jim Gibson	Station LW
Judy Hall	Station LX
John King	Station LY
Jane Lee	Station LZ
Bob Miller	Station MA
Alice Nelson	Station MB
Charlie Phillips	Station MC
Diana Reed	Station MD
Frank Scott	Station ME
Grace Turner	Station MF
Henry Walker	Station MG
Irene Young	Station MH
Jack Ziegler	Station MI
Jill Adams	Station MJ
Jim Baker	Station MK
Judy Clark	Station ML
John Evans	Station MN
Jane Foster	Station MO
Bob Gibson	Station MP
Alice Hall	Station MQ
Charlie King	Station MR
Diana Lee	Station MS
Frank Miller	Station MT
Grace Nelson	Station MU
Henry Phillips	Station MV
Irene Reed	Station MW
Jack Scott	Station MX
Jill Turner	Station MY
Jim Walker	Station MZ
Judy Young	Station NA
John Ziegler	Station NB
Jane Adams	Station NC
Bob Baker	Station ND
Alice Clark	Station NE
Charlie Evans	Station NF
Diana Foster	Station NG
Frank Gibson	Station NH
Grace Hall	Station NI
Henry King	Station NJ
Irene Lee	Station NK
Jack Miller	Station NL
Jill Nelson	Station NM
Jim Phillips	Station NN
Judy Reed	Station NO
John Scott	Station NP
Jane Turner	Station NQ
Bob Walker	Station NR
Alice Young	Station NS
Charlie Ziegler	Station NT
Diana Adams	Station NU
Frank Baker	Station NV
Grace Clark	Station NW
Henry Evans	Station NX
Irene Foster	Station NY
Jack Gibson	Station NZ
Jill Hall	Station OA
Jim King	Station OB
Judy Lee	Station OC
John Miller	Station OD
Jane Nelson	Station OE
Bob Phillips	Station OF
Alice Reed	Station OG
Charlie Scott	Station OH
Diana Turner	Station OI
Frank Walker	Station OJ
Grace Young	Station OK
Henry Ziegler	Station OL
Irene Adams	Station OM
Jack Baker	Station ON
Jill Clark	Station OO
Jim Evans	Station OP
Judy Foster	Station OQ
John Gibson	Station OR
Jane Hall	Station OS
Bob King	Station OT
Alice Lee	Station OU
Charlie Miller	Station OV
Diana Nelson	Station OW
Frank Phillips	Station OX
Grace Reed	Station OY
Henry Scott	Station OZ
Irene Turner	Station PA
Jack Walker	Station PB
Jill Young	Station PC
Jim Ziegler	Station PD
Judy Adams	Station PE
John Baker	Station PF
Jane Clark	Station PG
Bob Evans	Station PH
Alice Foster	Station PI
Charlie Gibson	Station PJ
Diana Hall	Station PK
Frank King	Station PL
Grace Lee	Station PM
Henry Miller	Station PN
Irene Nelson	Station PO
Jack Phillips	Station PP
Jill Reed	Station PQ
Jim Scott	Station PR
Judy Turner	Station PS
John Walker	Station PT
Jane Young	Station PU
Bob Ziegler	Station PV
Alice Adams	Station PW
Charlie Baker	Station PX
Diana Clark	Station PY
Frank Evans	Station PZ
Grace Foster	Station QA
Henry Gibson	Station QB
Irene Hall	Station QC
Jack King	Station QD
Jill Lee	Station QE
Jim Miller	Station QF
Judy Nelson	Station QG
John Phillips	Station QH
Jane Reed	Station QI
Bob Scott	Station QJ
Alice Turner	Station QK
Charlie Walker	Station QL
Diana Young	Station QM
Frank Ziegler	Station QN
Grace Adams	Station QO
Henry Baker	Station QP
Irene Clark	Station QQ
Jack Evans	Station QR
Jill Foster	Station QS
Jim Gibson	Station QT
Judy Hall	Station QU
John King	Station QV
Jane Lee	Station QW
Bob Miller	Station QX
Alice Nelson	Station QY
Charlie Phillips	Station QZ
Diana Reed	Station RA
Frank Scott	Station RB
Grace Turner	Station RC
Henry Walker	Station RD
Irene Young	Station RE
Jack Ziegler	Station RF
Jill Adams	Station RG
Jim Baker	Station RH
Judy Clark	Station RI
John Evans	Station RJ
Jane Foster	Station RK
Bob Gibson	Station RL
Alice Hall	Station RM
Charlie King	Station RN
Diana Lee	Station RO
Frank Miller	Station RP
Grace Nelson	Station RQ
Henry Phillips	Station RR
Irene Reed	Station RS
Jack Scott	Station RT
Jill Turner	Station RU
Jim Walker	Station RV
Judy Young	Station RW
John Ziegler	Station RX
Jane Adams	Station RY
Bob Baker	Station RZ
Alice Clark	Station SA
Charlie Evans	Station SB
Diana Foster	Station SC
Frank Gibson	Station SD
Grace Hall	Station SE
Henry King	Station SF
Irene Lee	Station SG
Jack Miller	Station SH
Jill Nelson	Station SI
Jim Phillips	Station SJ
Judy Reed	Station SK
John Scott	Station SL
Jane Turner	Station SM
Bob Walker	Station SN
Alice Young	Station SO
Charlie Ziegler	Station SP
Diana Adams	Station SQ
Frank Baker	Station SR
Grace Clark	Station SS
Henry Evans	Station ST
Irene Foster	Station SU
Jack Gibson	Station SV
Jill Hall	Station SW
Jim King	Station SX
Judy Lee	Station SY
John Miller	Station SZ
Jane Nelson	Station TA
Bob Phillips	Station TB
Alice Reed	Station TC
Charlie Scott	Station TD
Diana Turner	Station TE
Frank Walker	Station TF
Grace Young	Station TG
Henry Ziegler	Station TH
Irene Adams	Station TI
Jack Baker	Station TJ
Jill Clark	Station TK
Jim Evans	Station TL
Judy Foster	Station TM
John Gibson	Station TN
Jane Hall	Station TO
Bob King	Station TP
Alice Lee	Station TQ
Charlie Miller	Station TR
Diana Nelson	Station TS
Frank Phillips	Station TT
Grace Reed	Station TU
Henry Scott	Station TV
Irene Turner	Station TW
Jack Walker	Station TX
Jill Young	Station TY
Jim Ziegler	Station TZ
Judy Adams	Station UA
John Baker	Station UB
Jane Clark	Station UC
Bob Evans	Station UD
Alice Foster	Station UE
Charlie Gibson	Station UF
Diana Hall	Station UG
Frank King	Station UH
Grace Lee	Station UI
Henry Miller	Station UJ
Irene Nelson	Station UK
Jack Phillips	Station UL
Jill Reed	Station UM
Jim Scott	Station UN
Judy Turner	Station UO
John Walker	Station UP
Jane Young	Station UQ
Bob Ziegler	Station UR
Alice Adams	Station US
Charlie Baker	Station UT
Diana Clark	Station UU
Frank Evans	Station UV
Grace Foster	Station UW
Henry Gibson	Station UX
Irene Hall	Station UY
Jack King	Station UZ
Jill Lee	Station VA
Jim Miller	Station VB
Judy Nelson	Station VC
John Phillips	Station VD
Jane Reed	Station VE
Bob Scott	Station VF
Alice Turner	Station VG
Charlie Walker	Station VH
Diana Young	Station VI
Frank Ziegler	Station VJ
Grace Adams	Station VK
Henry Baker	Station VL
Irene Clark	Station VM
Jack Evans	Station VN
Jill Foster	Station VO
Jim Gibson	Station VP
Judy Hall	Station VQ
John King	Station VR
Jane Lee	Station VS
Bob Miller	Station VT
Alice Nelson	Station VU
Charlie Phillips	Station VV
Diana Reed	Station VW
Frank Scott	Station VX
Grace Turner	Station VY
Henry Walker	Station VZ
Irene Young	Station WA
Jack Ziegler	Station WB
Jill Adams	Station WC
Jim Baker	Station WD
Judy Clark	Station WE
John Evans	Station WF
Jane Foster	Station WG
Bob Gibson	Station WH
Alice Hall	Station WI
Charlie King	Station WJ
Diana Lee	Station WK
Frank Miller	Station WL
Grace Nelson	Station WM
Henry Phillips	Station WN
Irene Reed	Station WO
Jack Scott	Station WP
Jill Turner	Station WQ
Jim Walker	Station WR
Judy Young	Station WS
John Ziegler	Station WT
Jane Adams	Station WU
Bob Baker	Station WV
Alice Clark	Station WW
Charlie Evans	Station WX
Diana Foster	Station WY
Frank Gibson	Station WZ
Grace Hall	Station XA
Henry King	Station XB
Irene Lee	Station XC
Jack Miller	Station XD
Jill Nelson	Station XE
Jim Phillips	Station XF
Judy Reed	Station XG
John Scott	Station XH
Jane Turner	Station XI
Bob Walker	Station XJ
Alice Young	Station XK
Charlie Ziegler	Station XL
Diana Adams	Station XM
Frank Baker	Station XN
Grace Clark	Station XO
Henry Evans	Station XP
Irene Foster	Station XQ
Jack Gibson	Station XR
Jill Hall	Station XS
Jim King	Station XT
Judy Lee	Station XU
John Miller	Station XV
Jane Nelson	Station VX
Bob Phillips	Station VY
Alice Reed	Station VZ
Charlie Scott	Station WA
Diana Turner	Station WB
Frank Walker	Station WC
Grace Young	Station WD
Henry Ziegler	Station WE
Irene Adams	Station WF
Jack Baker	Station WG
Jill Clark	Station WH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>01150</b> 1. PLACE OF DEATH a. COUNTY <u>Pr. Geo.</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM, MD</u> c. LENGTH OF STAY IN 1b <u>16 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS Nursing Home</u>						<b>01120</b> 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>5418-1st St NE R. WASH. DC</u> <b>D.C.</b> b. COUNTY <u>47-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u> d. STREET ADDRESS <u>5418-1st St NE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>IRENE BAXTER COATES</u>			4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1966</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9/15/1869</u>			9. AGE (In years last birthday) <u>96</u> yrs.			10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>15</u> Hours <u>15</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>						13. FATHER'S NAME <u>Wm Henry Baxter</u>					
14. MOTHER'S MAIDEN NAME <u>HARRIET F. PITTS</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>					
16. SOCIAL SECURITY NO. <u>—</u>						17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerotic cardiovascular disease</u> DUE TO (c) <u>years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho-pneumonia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>50</u> , to <u>1/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/12</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Alfred S. Norton</u>						22b. DATE SIGNED <u>1/12/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>						22d. ADDRESS <u>7716 Dwight Dr. Bethesda Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL &amp; BURIAL</u>				23b. DATE THEREOF <u>1-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE, VIRGINIA</u>				23d. LOCATION (City, town or county) (State) <u>WASH &amp; SHAW</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>						25a. REC'D BY REGISTRAR <u>Jan 17 1966</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

01180

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01151						01121					
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville,</b> d. STREET ADDRESS <b>3741 Powder Mill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Laura</b>			First Middle Last <b>Commons</b>			4. DATE OF DEATH <b>January 21 1966</b>			Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-13-01</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Waitress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Walden</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Woodrow Wilson Woody</b> Address <b>3741 Powder Mill Rd. Beltsville, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>1960</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of ethmoid bones with</b> DUE TO <b>Generalized metastasis</b> (c)										INTERVAL BETWEEN ONSET AND DEATH <b>10 mo</b> <b>10 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 19</b> , 1966, to <b>Jan. 21</b> , 1966, that <del>he</del> (we) last saw the deceased alive on <b>Jan. 21</b> , 1966, and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>William D. Rosson</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/21/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>William D. Rosson, MD.</b>						22d. ADDRESS <b>5701 85th Ave, Hyattsville, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1-25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace Christian Church Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Savage, Maryland</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>						ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>Jan 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01151

01151

CENTRICATE OF DEATH

Prince George's Hospital

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Prince George's Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01152 Item #9 Film #4372 1/24/66 pc											
01122											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 14 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3220 Chillum Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Archie J Connor Sr.						4. DATE OF DEATH Month Day Year January 12 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1892		9. AGE (In years last birthday) 74/73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Chauffeur		11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles Connor						14. MOTHER'S MAIDEN NAME Mae Hassett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 131 03 1288		17. INFORMANT Archie J. Connor Jr. same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Chronic Bronchitis & Emphysema underlying cause last. Pulmonary Carcinoma, Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Carcinoma, Diabetes Mellitus											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 1965, 19, to Jan 12, 1966, that (I) (we) last saw the deceased alive on Jan. 11, 1966, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE O. Sahakyan						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan. 12, 1966			
22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan						22d. ADDRESS 5813 Landover Rd. Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/65		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Middle Village L.I. N.Y.					
24. FUNERAL DIRECTOR F. Laschi Sons - Hyattsville, Md.						25a. REC'D BY REGISTRAR JAN 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01153

01123

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. CDUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u>		c. LENGTH OF STAY IN lb <u>6 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> <u>16-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>				d. STREET ADDRESS <u>7709- Riverdale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eleanor Sayles</u>				Last <u>Cooley</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 31, 1912</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles E. Sayles</u>			
14. MOTHER'S MAIDEN NAME <u>Emma ?</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>577-09-1494</u>				17. INFORMANT <u>Mrs. Charles Funkhouser - 8712 - 63d Ave., College Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of left breast</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>3 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>act.</u> 19 <u>60</u> , to <u>1/26/</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> 19 <u>66</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>1/26/66</u>		22c. PHYSICIAN'S NAME (Type) <u>F. E. Musser, MD</u>	
22d. ADDRESS <u>4410 24th Ave, Hyattsville, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				25a. REC'D BY REGISTRAR <u>55B 3</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div> <div>1</div> <div>01154</div> <div>01124</div> </div> <div> <div> <div>1</div> <div>2</div> <div>3</div> </div> <div> <div>4</div> <div>5</div> <div>6</div> </div> </div> <div> <div>7</div> <div>8</div> <div>9</div> </div> <div> <div>10</div> <div>11</div> <div>12</div> </div>											
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JOURNAL OF DOCUMENTATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>1</div> <div>01155</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>01125</div> </div>											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN ID <b>7 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PRINCE GEORGE GENERAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>P.G.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COLMAR MANOR</b> d. STREET ADDRESS <b>3418 41st. AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>OLIVER</b> Middle <b>E.</b> Last <b>CREELMAN</b>						4. DATE OF DEATH Month <b>JANUARY</b> Day <b>22</b> Year <b>1966</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-28-12</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>16</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Eddy Creelman</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Jane Perry</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-30-3599</b>		17. INFORMANT <b>Mrs. Rose M. Creelman (above address)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary hypertension</b> DUE TO (c) <b>at least</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>dress</b> INTERVAL BETWEEN ONSET AND DEATH <b>3-4 yrs</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 16, 1966</b> , to <b>JAN. 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>JAN. 22, 1966</b> , and that death occurred at <b>3P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b>						22b. DATE SIGNED <b>1/23/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>						22d. ADDRESS <b>2601 Riverside Rd. Lorton Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>			
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				24b. ADDRESS <b>Maryland</b>		25a. REC'D BY REGISTRAR <b>Jan 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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CHRYSTAL

FRANCIS GEORGE

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CHRYSTAL

WHITE

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1-11-12

23

JANUARY 23

TO: [illegible] FROM: [illegible]

JAN 23 1962

JAN 23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. Hyatts. CHILLUM</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ADA SACON DA Nursing Home</u>					d. STREET ADDRESS <u>5459 16th Ave 16-1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>EULA Lee DAVIS</u>					4. DATE OF DEATH Month <u>JAN</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12 1881</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fountain Inn S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>J. E. WALKER</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM H. JONES</u>			Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Viral infection, systemic</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 week</u> <u>5 yrs</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>66</u> to <u>1/14</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>1/14</u> , 19 <u>66</u> and that death occurred at <u>10</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Norman J. Conner</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/14/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Norman J. Conner</u>					22d. ADDRESS <u>3503 Pennys Mt Rd, Annapolis</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>17 JAN 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CHURCH CEM</u>			23d. LOCATION (City, town or county) (State) <u>GREENVILLE, S. CAROLINA</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>					ADDRESS <u>Riversdale, Md.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>JAN 20 1966</u>										

MEDICAL CERTIFICATION



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
SUBJECT: [illegible]

[illegible text]

[illegible text]

Wm. C. Rensselaer, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01157					01127				
1. PLACE OF DEATH a. COUNTY Prince George's					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					b. COUNTY Prince George's				
c. LENGTH OF STAY IN 1b 3 days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine 16-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS --				
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward DeMarr					4. DATE OF DEATH Month Day Year January 16 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1966		9. AGE (In years last birthday) yrs. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Prince George, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME David R. De Marr					14. MOTHER'S MAIDEN NAME Catherine Windsor				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT David R. De Marr		Address Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, subcortical; Bilateral 7600 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 14 Jan, 1966, to 16 Jan, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at 10:40 AM, from the causes and on the date stated above.									
22a. SIGNATURE Robert B. Sasscer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/17/66			
22c. PHYSICIAN'S NAME (Type) Robert B. Sasscer				22d. ADDRESS RFD Bx 2150, Upper Marlboro, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-66		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens		23d. LOCATION (City, town or county) (State) Waldorf, Md.			
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.				25a. REC'D BY REGISTRAR J. Charles Judge		25b. REGISTRAR'S SIGNATURE J. Charles Judge			
DATE JAN 20 1966									

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DEPARTMENT OF DEATH

Prison Governor's General Hospital  
Birmingham

Jan. 19, 1962

David R. B. M.



117196

Prison Governor's General Hospital, Birmingham, No.

Robert E. Bennett

Prison Governor's General Hospital, Birmingham, No. 117196

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

01158

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>4403 38th. Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Arthur Dendy</b>		4. DATE OF DEATH Month Day Year <b>1 4 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1908</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sell</b>	
11. BIRTHPLACE (State or foreign country) <b>Pickens Co., S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dendy</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Hammonds</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Multiple fractures</b> DUE TO <b>Trauma- auto accident</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by car.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12:20 p.m. 1-2- 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Prince George County, Md.</b>		20f. (City or town) (County) (State) <b>Queens Chapel Road and Jamestown Road, Hyatts.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-5-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Spartanbury Co., S.C.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>Jan 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> <u>16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>2902</u> <u>2907 Arundel Road, Apt. 1</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph DePre</u>		4. DATE OF DEATH <u>1</u> <u>19</u> <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1884</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days 19 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Prtg. Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William DePre</u>		14. MOTHER'S MAIDEN NAME <u>Anna Moreio</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-52-0780</u>	
17. INFORMANT <u>Mrs. Minnie C. DePre (above address)</u>		Address <u>(Wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>over 5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-19-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/22/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's</u> ADDRESS <u>Mt. Rainier</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1966</u>	
Funeral Home Inc. <u>Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>6 mos., 11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital, Glenn Dale, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47-3</b> d. STREET ADDRESS <b>331 9th St., S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>G.</b> Last <b>Driver</b>		4. DATE OF DEATH Month <b>1</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/17/1905</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Emanuel Shorter</b>	
14. MOTHER'S MAIDEN NAME <b>Julia Driver</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Decedent</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease with remote and recent myocardial infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular accident with left hemiparalysis, traumatic, 1952</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>7/17/1965</b> , to <b>1/12/1966</b> , that (we) last saw the deceased alive on <b>1/12/1966</b> , and that death occurred at <b>2:00</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>1/12/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-17-66</b>		23b. DATE THEREOF <b>1-17-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony M.P. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Md.</b>	
24. FUNERAL DIRECTOR <b>Universal F. Home</b>		25a. REC'D BY REGISTRAR <b>1 JAN 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

11/13/60

11/13/60

Prince George

Prince George (Kwakiwilt)

Nov. 11, 1960

Washington, D. C.

Glenn Dale Hospital, Glenn Dale, Md.

221 Old Rd., N. W.

James

G.

Driver

60

11/17/1960

Native

Male

Laborer

Washington, D. C.

U.S.A.

General Director

Julia Driver

Unknown

Residence

11/17/1960

Nov. 17, 1960

11/17/60

11/17/1960

Glenn Dale Hospital

Glenn Dale, Md.

Nov. 17, 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>Prince Geo.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					b. COUNTY <b>Prince George's</b>									
c. LENGTH OF STAY IN lb <b>D.O.A.</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					d. STREET ADDRESS <b>1107 Montrose Avenue</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>Blanche</b>			First			Middle <b>O</b>			Last <b>Earp</b>					
4. DATE OF DEATH <b>January 18 1966</b>			Month			Day			Year					
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>January 25 1892</b>					
9. AGE (in years last birthday) <b>73</b>			IF UNDER 1 YEAR Months			IF UNDER 24 HRS. Days			IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. Veterans Bureau</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Simpsonville, Md.</b>				
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					13. FATHER'S NAME <b>John Wesley Earp</b>					14. MOTHER'S MAIDEN NAME <b>Eveline Carr</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b></b>					17. INFORMANT <b>Lewis W. Earp, Jr. Carverville</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> (c) <b>same</b>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>1-18</b> , 19 <b>66</b> , that (I) ( <b>was</b> ) last saw the deceased alive on <b>1-18</b> , 19 <b>66</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>Idolo Pierandrei</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Idolo Pierandrei</b>						22d. ADDRESS <b>305 Prince Geo. St., Laurel, Md.</b>		22b. DATE SIGNED <b>1-18-66</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-21-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Any Hill Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Laurel Md</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Al Witt Canalehan</b>						ADDRESS <b>Laurel, Md</b>		25a. REC'D BY REGISTRAR <b>JAN 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

01138

01138

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

White

White

1-15-50

101 Prince Geo. St., Laurel, Md.

Mr. John J. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>4 mo., 18 days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D. C.</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>						e. STREET ADDRESS <b>203 16th Street, N. E.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ulysses</b>		First <b>S.</b>		Middle <b>Edwards</b>		Last <b>Edwards</b>		4. DATE OF DEATH Month <b>1</b> Day <b>28</b> Year <b>19 66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/21/1879</b>		9. AGE (In years last birthday) <b>86</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Edwards</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Roberts</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>125-59-2922</b>		17. INFORMANT <b>Decedent</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Bronchopneumonia</b> IMMEDIATE CAUSE (a) <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Generalized arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign prostatic hypertrophy with obstructive uropathy and secondary chronic pyelonephritis; urethral-perineal fistula</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Glenn Dale, Md.</b>		(County) (State)	
21. I certify that (this hospital) attended the deceased from <b>9/10 1965</b> to <b>1/28 1966</b> , that (we) last saw the deceased alive on <b>1/28 1966</b> , and that death occurred at <b>9:40 P.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Moe Weiss</b>				M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-28-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-4-66</b>		23b. DATE THEREOF <b>2-4-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Pr. Geo. CO. Md.</b>			
24. FUNERAL DIRECTOR <b>S. M. H. Funeral Home</b>				ADDRESS <b>2116-18th St. N.E.</b>		25a. REC'D BY REGISTRAR <b>DATE 2-1-66</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

FEB 16 1966

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Washington, D.C.

Office of the Surgeon General

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01133

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>103-12 Liberty Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Esposito</u> Last <u>Esposito</u>		4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 April 1917</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raffaele Esposito</u>		14. MOTHER'S MAIDEN NAME <u>Carmela Deloasaca</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Otilde Esposito, Ave. Ozonw Park,</u>		Address <u>103-12 Liberty</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>From acute occlusion of anterior descending coronary artery</u> (c) <u>From Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>.Y minutes</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-13-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Jan. 17, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery Middleville, L.I., N.Y.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., Riverdale, Md.</u>		25. REC'D BY REGISTRAR <u>Jan 17 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



6611

1911

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01164 CERTIFICATE OF DEATH 01134											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN ID <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>401 Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Ellen</b> Middle <b>Jane</b> Last <b>Evans</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>2</b> Year <b>1966</b>		5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Thomas Johnson</b>					14. MOTHER'S MAIDEN NAME <b>Not Obtainable</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James H. Watson</b> Address <b>902 Prince St., Alex., Va.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> <b>171X</b> DUE TO (b) <b>Severe Anemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Advanced CA of Cervix</b>									INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from <b>12/29</b> , 1965, to <b>1/2</b> , 1966, that (we) last saw the deceased alive on <b>1/2</b> , 1966, and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.									22b. DATE SIGNED		
22a. SIGNATURE <b>Dr. William R. Greco</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan. 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <b>Ruckersville, Virginia</b>				
24. FUNERAL DIRECTOR <b>Cunningham Funeral Home, Inc.</b>			ADDRESS <b>Alexandria, Va.</b>		25a. REC'D BY REGISTRAR <b>JAN 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01135

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> 47-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>917 Delaware Avenue, S.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hazel Lorraine Fastnaught</u>		4. DATE OF DEATH Month Day Year <u>1 2 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 March 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-Wife &amp; Chambermaid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaning</u>	9. AGE (In years last birthday) yrs. <u>52</u>
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Breeden</u>		14. MOTHER'S MARRIED NAME <u>Pearl Muck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-48-4134</u>	
17. INFORMANT <u>Barbara Price</u>		Address <u>Millside, Md 1203-5th Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>From Arteriosclerotic heart disease</u> DUE TO <u>And pulmonary fibrosis</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>min.</u>  years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-3-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Pt. Geo Co., Md</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JAN 7 1966</u>	
ADDRESS <u>5801 Cleveland Ave Riverdale, Md</u>		25b. REGISTRAR'S SIGNATURE	

01130

1113



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01166

01136

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1210 8th St. N. W.</b>	
3. NAME OF DECEASED (Type or print) <b>Geneva</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>separated x</b>	8. DATE OF BIRTH <b>7/10/1918</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	9. AGE (in years last birthday) <b>47</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>King George Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Thornton</b>		14. MOTHER'S MAIDEN NAME <b>Della Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-28-4430</b>	17. INFORMANT <b>Decedent</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic cor pulmonale</b> <b>0021</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <b>Pulmonary tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yr. 8 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic pyelonephritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> <b>1965</b> to <b>1/8</b> <b>1966</b> , that (I) (we) last saw the deceased alive on <b>1/8</b> <b>1966</b> , and that death occurred at <b>9:35 A.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>1/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Jan 13, 1966</b>	23b. DATE THEREOF <b>Jan 13, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>	23d. LOCATION (City, town or county) (State) <b>Switzland Maryland</b>
24. FUNERAL DIRECTOR <b>Universal F. Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>816 H St NE</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

.05, .01, .001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

\*acute parotitis on right, 7/64, resolved.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01167 CERTIFICATE OF DEATH 01137											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>3 yrs., 8 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47-3</b> d. STREET ADDRESS <b>1711 E. Capitol St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Nellie</b>			First <b>C.</b>			Middle <b>Flynn</b>			Last <b>Jan.</b>		
4. DATE OF DEATH <b>16</b>		Month <b>19</b>		Year <b>1966</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11/23/1889</b>			9. AGE (In years last birthday) <b>76</b>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Nat'l Ed. Assn.</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Thomas Flynn</b>			14. MOTHER'S MAIDEN NAME <b>Mary McGraw</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Decedent</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis, far advanced</b> <b>0021</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>36 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary artery disease with posterior myocardial infarction, history; essential hypertension, controlled; thyroidectomy, 1929; *</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <b>May 14</b> <b>1958</b> to <b>Jan. 17</b> , <b>1966</b> , that (I) (we) last saw the deceased alive on <b>Jan. 17</b> , <b>1966</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.			22a. SIGNATURE <b>Moe Weiss</b>		
22b. DATE SIGNED <b>1/17/66</b>			22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>			22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/19/1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Wash. D.C.</b>			23d. LOCATION (City, town or county) (State) <b>Wash. D.C.</b>		
24. FUNERAL DIRECTOR <b>Matthew 131-11th St. S.E. DC</b>			25a. REC'D BY REGISTRAR <b>1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

0118

0116

Prince Georges

1 Dec. 8  
2 Dec.

Glenn Dale (viral)

Washington

Glenn Dale Hospital

1711 E. Capitol St.

Leila

U.

Given

USA

Female White

11/23/32

11

Clara

Has I H. Allen

Washington, D. C.

USA

Thomas Ely

11/11/32

No

11/11/32

Polymorphous exanthematous, far advanced

32 years

Coronary artery disease with posterior myocardial infarction, extensive;  
essential hypertension, controlled; rheumatoid, 1932 \*

Jan. 11

Jan. 10

Jan. 9

Jan. 8

White

Glenn Dale Hospital  
Glenn Dale, Maryland

See Nelson, W. D.

\* Evidence of a viral etiology is not certain

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01168

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01138

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Freeman</b>		4. DATE OF DEATH Month <b>1</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Dec. 1887</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Huckster</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Freeman</b>		14. MOTHER'S MAIDEN NAME <b>Annie Bell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Elizabeth Young</b>		Address <b>311-W. 116 N.Y.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>From arteriosclerotic heart disease</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus - known over 1 year</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>1-14-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-17-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West Harman</b>	23d. LOCATION (City or Town) (County) (State) <b>Highland Park Md</b>
24. FUNERAL DIRECTOR <b>A.S. Washington Son</b>		25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	

1113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01169					01139				
1. PLACE OF DEATH a. COUNTY Prince Georges					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale					c. LENGTH OF STAY IN 1b MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale - HYATTSVILLE 16-1				
d. STREET ADDRESS 3912 Queensbury Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Dottie MIDDLE Jean LAST Galentine					4. DATE OF DEATH Month 1 Day 20 Year 19 66				
5. SEX Fe.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-27-11		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (County & State, or foreign country) Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Galentine, Homer P.					14. MOTHER'S MAIDEN NAME Henry, Kathryn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218 24 2314		17. INFORMANT LEONA C. GALENTINE			Address SAME AS #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Congestive heart failure. (b) Arterio sclerotic heart dis. (c) DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1946 to Jan 20, 1966, that (I) (we) last saw the deceased alive on Jan 20, 1966, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE L W Malin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1-20-66	
22c. PHYSICIAN'S NAME (Type) L W Malin MD				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-22-1966		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY			23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND		
24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 24 1966		25b. REGISTRAR'S SIGNATURE John Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01170		01140							
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>2 mos., 3 wks.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47-3</b> d. STREET ADDRESS <b>1510 P St., N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Nelson</b>		First <b>Nelson</b>		Middle <b>W.</b>		Last <b>Gatewood</b>		4. DATE OF DEATH Month <b>1</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/5/1922</b>		9. AGE (In years last birthday) <b>43</b> IF UNDER 1 YEAR: Months <b>4</b> Days <b>12</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Stern Shoe Repair</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Gatewood</b>				14. MOTHER'S MAIDEN NAME <b>Alberta Lomax</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>12/49-12/50</b>		17. INFORMANT <b>Decedent</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, right lung, with general-ized metastases</b> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>11:45</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>10/22/1965</b> to <b>1/12/1966</b> , that <del>he</del> (we) last saw the deceased alive on <b>1/12/1966</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Moe Weiss</i>				M.D. <b>Moe Weiss, M. D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/12/1966</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>		23d. LOCATION (City, town or county) (State) <b>FT. MEYER, VA.</b>			
24. FUNERAL DIRECTOR <i>Charles B. Farrell</i>				ADDRESS <i>309 P St. N.W. Wash. D.C.</i>		25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



01140

01170

Police George

Glenn Dale (Vocal) 2 mos. 3 wks. Washington, D. C.

Glenn Dale Hospital 1910 P. 21. N. W.

Glenn Dale Hospital 1910 P. 21. N. W.

Glenn Dale Hospital 1910 P. 21. N. W.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> c. LENGTH OF STAY IN 1b <u>5 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southern Maryland Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> d. STREET ADDRESS <u>7737 Schultzy Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARY A. GEBHARDT</u> First Middle Last						4. DATE OF DEATH <u>JAN 27 1966</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/23/00</u> yrs.		9. AGE (in years last birthday) <u>65</u> Months Days Hours Min.		10. IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Walter Kiplinger</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Shugrue</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary J. Gebhardt</u> Address <u>Same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 5271 DUE TO (b) <u>Chronic Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>with chronic congestive failure and chronic pulmonary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE VIRAL RESPIRATORY INFECTION (OPPER)</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 19.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED White <input type="checkbox"/> NOT White <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12, 1966</u> to <u>Pres. 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 27 1966</u> and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Arthur Shaver Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>						22b. DATE SIGNED <u>1/27/66</u>		22d. ADDRESS <u>854 BRANCH AVE. CLINTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 29-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>Simmons Brothers</u> ADDRESS <u>Wash., DC</u>				25a. REC'D BY REGISTRAR <u>FEB 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

25220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) USAF HOSP ANDREWS AFB c. LENGTH OF STAY IN 1b 1 HR d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSP ANDREWS AFB					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 7305 PINEHURST DR e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) LEONARD DONALD GEIGER			4. DATE OF DEATH JAN 9 19 66		5. SEX MALE 6. COLOR OR RACE CAUC 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PHOENIXVILLE PA			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LEONARD F GEIGER					14. MOTHER'S MAIDEN NAME ANGELINE HART						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II			16. SOCIAL SECURITY NO. 181-01-6332		17. INFORMANT WIFE			Address SAME AS ITEM #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Standstill + Hemagic Poison</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Postoperative Myocardial Infarction</i> DUE TO (c) <i>Sclerosis, Rt. Coronary Artery</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Healed Dorsal Ulcer</i>								INTERVAL BETWEEN ONSET AND DEATH 40 1 hr. UNK.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1545 9 Jan 19 66, to 1625 9 Jan 19 66, that (I) (we) last saw the deceased alive on 9 Jan 19 66, and that death occurred at 4:20 PM from the causes and on the date stated above.											
22a. SIGNATURE <i>Angelo P. Spoto</i>					22b. DATE SIGNED 9 Jan 66			22c. PHYSICIAN'S NAME (Type) ANGELO P. SPOTO, CAPT, USAF, MC			
22d. ADDRESS USAF HOSP ANDREWS AFB WASH DC					22e. REC'D BY REGISTRAR JAN 13 1966						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1-13-66		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION (City, town or county) (State) ARLINGTON VA			
24. FUNERAL DIRECTOR W W CHAMBLAS 517 W ST SE					25a. REC'D BY REGISTRAR JAN 13 1966					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

01110

RECEIVED BY DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>01173</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>01143</p> </div> </div>															
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3401 Bunker Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Otto</b> First <b>L</b> Middle <b>Gerhardt</b> Last			4. DATE OF DEATH <b>January</b> Month <b>21</b> Day <b>19</b> Year <b>66</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>2-5-92</b>			9. AGE (In years last birthday) <b>73</b> yrs.			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Julius Gerhardt</b>						14. MOTHER'S MAIDEN NAME <b>Theresa Bishop</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT <b>Hospital Records</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senesion pneumothorax</b> <b>52771</b> DUE TO (b) <b>Ruptured bleb</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>pulmonary emphysema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>advanced arteriosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1/5</b> , 19 <b>66</b> to <b>1/21</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>1/21</b> , 19 <b>66</b> , and that death occurred at <b>11:00</b> M, from the causes and on the date stated above.															
22a. SIGNATURE <b>W. M. M. D.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <b>1/21/66</b>									
22c. PHYSICIAN'S NAME (Type) <b>W. M. M. D.</b>						22d. ADDRESS <b>3503 Penny St Mt Rainier</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/24/66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>						
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>						25a. REC'D BY REGISTRAR <b>JAN 26 1966</b>			25b. REGISTRAR'S SIGNATURE <b>J. M. Judge</b>						

MEDICAL CERTIFICATION



Hospital Records



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01174 CERTIFICATE OF DEATH 01144

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham Md c. LENGTH OF STAY IN ID 1 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Magnolia Gardens Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. d. STREET ADDRESS 5607 Newton Street,. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REBECCA G. GIBBS First Middle Last		4. DATE OF DEATH Jan. 6 1966 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1905 9. AGE (in years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Guy Grindle		14. MOTHER'S MAIDEN NAME Sara Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213 38 1752 17. INFORMANT Wm E Gibbs Jr Hyattsville, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 517x Acute laryngeal edema DUE TO (b) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus, Cerebral arteriosclerosis, Cerebral atrophy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 to 1-6, 1966, that (I) (we) last saw the deceased alive on 1-4 1966, and that death occurred at 8:59 PM from the causes and on the date stated above.			
22a. SIGNATURE Donald C. Ecken		22b. DATE SIGNED 1-6-66	
22c. PHYSICIAN'S NAME (Type) DONALD C. ECKEN		22d. ADDRESS 3500 Endicott Ave Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/10/66	
23c. NAME OF CEMETERY OR CREMATORY St. Lunsden		23d. LOCATION (City, town or county) (State) Colmar Manor Md	
24. FUNERAL DIRECTOR F. Lisch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JAN 10 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

01175

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1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Adelphi)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Adelphi) 16-1			
c. LENGTH OF STAY IN 1b 2years 2 mos.				d. STREET ADDRESS 8910 Riggs Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8910 Riggs Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Josephine		First Middle Last Gingras		4. DATE OF DEATH January 11 1966		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1872	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious Sister		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Manchester, New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Eusebe Gingras				14. MOTHER'S MAIDEN NAME Cedeline Martel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother Mary Armand, R.D.-7. Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO Generalized arteriosclerosis & cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 5 days 15 yrs. -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1963 to Jan. 11, 1966, that (I) (we) last saw the deceased alive on Jan. 9, 1966, and that death occurred at 8:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE James L. Haubach				22b. DATE SIGNED 1/11/66		22c. PHYSICIAN'S NAME (Type) James L. Haubach	
22d. ADDRESS 1903 Wooded Way, Adelphi, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-14-66		23c. NAME OF CEMETERY OR CREMATORY REGINA CONVENT CEMETERY		23d. LOCATION (City, town, or county) PRINCE GEORGES, MARYLAND (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				25a. REC'D BY REGISTRAR JAN 14 1966		25b. REGISTRAR'S SIGNATURE Johannes Judge	
ADDRESS WASH. D.C. 3821 14TH. ST. N. W.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01176					01146						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Prince George MARYLAND					a. STATE Maryland b. COUNTY Pr. Geo.						
b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) Hillside 16-1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS 5801--L--St., S. E.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First MARY Middle MARGARET Last GIOVINAZZO					Month Jan. 29-th Day Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21-1913		9. AGE (in years last birthday) 53 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, DC			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Harry Beckert					14. MOTHER'S MAIDEN NAME Margaret Jackson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.						
17. INFORMANT Dominick J. Giovino					Address Same as Item # 2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute coronary occlusion DUE TO (b) Coronary arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1958 to 1-29-1966, that (I) (we) last saw the deceased alive on 1-25-1966, and that death occurred at 3 PM, from the causes and on the date stated above.											
22a. SIGNATURE Peter Duus					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-29-66				
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus					22d. ADDRESS 6124 Central Ave, Capitol Hghts, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 2-1966		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum			23d. LOCATION (City, town or county) (State) Bladensburg, Maryland				
24. FUNERAL DIRECTOR Simmons Bros.					ADDRESS 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR FEB 1 1966				
							25b. REGISTRAR'S SIGNATURE				

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME  
5M 1/63

<div> <div> 1 FOR STATE HEALTH DEPT. </div> <div> 01177 </div> </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH  Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  MEDICAL EXAMINER'S CERTIFICATE OF DEATH  Item #9 Film #4373 2/10/66 pg </div> <div> 01147 </div>													
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> <u>16-1</u> d. STREET ADDRESS <u>8936 Dangerfield Place</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN lb <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George A Goldsborough</u> First Middle Last						4. DATE OF DEATH <u>1 25 19 66</u> Month Day Year							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 13, 1909</u> <u>57</u> yrs.		9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>							
11. BIRTHPLACE (State or foreign country) <u>ST MARYS COUNTY, MD</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>							
13. FATHER'S NAME <u>BENJAMIN F. GOLDSBOROUGH</u>						14. MOTHER'S MAIDEN NAME <u>ANN NORRIS</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>577-28-6557</u>							
17. INFORMANT <u>HELEN BYRNOR-TEMPLE HILLS, MD</u> Address													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>  <u>over 8 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>1-25-66</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1-28-66</u>				22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>				22d. LOCATION (City, town, or county) (State) <u>SPITLAND MD</u>	
23. FUNERAL DIRECTOR <u>W.W. CHAMBERS</u> ADDRESS <u>617 11th ST. SE</u>				24a. REC'D BY REGISTRAR <u>FEB 1 1966</u> DATE				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION



# UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE NATIONAL CENTER FOR HUMAN GENEALOGY

<p>NAME: _____</p>		<p>DATE: _____</p>	
<p>ADDRESS: _____</p>		<p>CITY: _____</p>	
<p>STATE: _____</p>		<p>ZIP: _____</p>	
<p>TELEPHONE: _____</p>		<p>AGE: _____</p>	
<p>SEX: _____</p>		<p>RACE: _____</p>	
<p>EDUCATION: _____</p>		<p>OCCUPATION: _____</p>	
<p>RELIGION: _____</p>		<p>POLITICAL: _____</p>	
<p>ETHNIC: _____</p>		<p>LANGUAGES: _____</p>	
<p>DIAGNOSIS: _____</p>		<p>TREATMENT: _____</p>	
<p>PROGNOSIS: _____</p>		<p>REMARKS: _____</p>	
<p>SIGNATURE: _____</p>		<p>DATE: _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>01178</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>Item 5 Film G 373</p> </div> <div> <p>Item #9 Film #373 271/66</p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>01148</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Prince George's</b> MARYLAND</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Md</b> b. COUNTY <b>Prince George's</b></p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><b>Cheverly Md</b></p>				<p>c. LENGTH OF STAY IN 1b</p> <p><b>D. O. A.</b></p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p><b>Riverdale</b></p>				<p>16-1</p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><b>Prince Georges General Hospital</b></p>						<p>d. STREET ADDRESS</p> <p><b>5606 Patterson Road</b></p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p><b>Edward</b> First <b>H.</b> Middle <b>-</b> Last <b>Goodwin</b></p>			<p>4. DATE OF DEATH</p> <p><b>Jan 30, 1966</b></p>			<p>Month <b>Jan</b> Day <b>30</b> Year <b>1966</b></p>			<p>9. AGE (In years last birthday)</p> <p><b>187/86</b> yrs.</p>		
<p>5. SEX <b>Male</b></p>		<p>6. COLOR OR RACE <b>white</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p><b>Feb 16, 1879</b></p>		<p>IF UNDER 1 YEAR</p> <p>Months <b>1</b> Days <b>16</b> Hours <b>0</b> Min. <b>0</b></p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Sheet Metal Worker</b></p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p><b>Building</b></p>				<p>11. BIRTHPLACE (County &amp; State, or foreign country)</p> <p><b>Washington D. C.</b></p>				<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>U S A</b></p>			
<p>13. FATHER'S NAME</p> <p><b>James E Goodwin</b></p>						<p>14. MOTHER'S MAIDEN NAME</p> <p><b>Catherine Free</b></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p> <p><b>no</b></p>				<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT</p> <p><b>Hospital record</b></p>				<p>Address <b>Cheverly, Md.</b></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b></p> <p><b>5271</b> DUE TO (b) <b>Coronary artery Disease</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Chronic Emphysema</b></p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>15 yrs.</b></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <b>19</b> p.m.</p>				<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1965</b> to <b>1-30, 1966</b>, that (I) (we) last saw the deceased alive on <b>1-30, 1966</b>, and that death occurred at <b>11</b> M, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE</p> <p><b>George Hageage</b></p>						<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>			<p>22b. DATE SIGNED</p> <p><b>2-1-66</b></p>		
<p>22c. PHYSICIAN'S NAME (Type)</p> <p><b>George Hageage</b></p>						<p>22d. ADDRESS</p> <p><b>3717-38th Ave College City, Md</b></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>			<p>23b. DATE THEREOF</p> <p><b>Feb 3, 1966</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><b>Congressional Cemetery</b></p>			<p>23d. LOCATION (City, town or county) (State)</p> <p><b>Washington D. C.</b></p>			
<p>24. FUNERAL DIRECTOR</p> <p><b>F. Gasch's Sons</b></p>						<p>ADDRESS</p> <p><b>Hyattsville, Md.</b></p>			<p>25a. RECEIVED BY REGISTRAR <b>FEB 7 1966</b> 25b. REGISTRAR'S SIGNATURE <b>James E. Gasch</b></p>		

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*[Faint, illegible handwriting, possibly bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

01179

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01149

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN ID <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>815 5th St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>E.</b> Middle <b>Gorham</b> Last		4. DATE OF DEATH <b>Jan.</b> Month <b>6</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>3/8/1900</b> 9. AGE (In years last birthday) <b>65</b> yrs. IF UNOER 1 YEAR Months Days Hours Min. <b>65</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, N. C.</b> 11. BIRTHPLACE (County & State, or foreign country) <b>USA</b> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John Gorham</b> 14. MOTHER'S MATEON NAME <b>Lettice Moore</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>unknown</b> 17. INFORMANT <b>decedent</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis, far advanced</b> 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a) <b>Chronic alcoholism; convulsive disorder secondary to alcoholism.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr., 3 mos.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIOENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURREO While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12/20</b> <b>8:00 AM</b> to <b>1/6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Moe Weiss</b> 22b. DATE SIGNED <b>1/6/66</b> 22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b> 22d. ADDRESS <b>Glenn Dale Hospital</b> <b>Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-13-66</b> 23b. DATE THEREOF <b>1-13-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Harmony m. F. Sem</b> 23d. LOCATION (City, town or county) (State) <b>Switzerland m d</b>		24. FUNERAL DIRECTOR <b>Universal F. Home</b> ADDRESS <b>816 H. St N.E.</b> 25a. REC'D BY REGISTRAR <b>W. H. H.</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Washington, D. C.

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1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 25

Chronic alcoholism; compulsive disorder secondary to alcoholism.

Green, John, 1901-1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01180 <span style="float: right;">01150</span>											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>38 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> d. STREET ADDRESS <b>1117 49th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Baby</b>			First <b>Baby</b>			Middle <b>Boy</b>			Last <b>"A" Graham</b>		
4. DATE OF DEATH <b>January 19 1966</b>		Month <b>January</b>		Day <b>19</b>		Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 18, 1966</b>		9. AGE (In years last birthday) <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Edward Leroy Graham</b>				14. MOTHER'S MAIDEN NAME <b>Fay Marie Salyers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>--</b>				17. INFORMANT <b>Fay Marie Salyers</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth, neonatal death</b> <b>7562</b> DUE TO <b>Twins birth</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Placental apoplexy</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that <b>Dr</b> (this hospital) attended the deceased from <b>Jan. 18</b> , 1966, to <b>Jan. 19</b> , 1966, that <b>we</b> last saw the deceased alive on <b>Jan. 19</b> , 1966, and that death occurred at <b>7:55 M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Leroy E. Hoeck</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan. 20, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leroy E. Hoeck, M.D.</b>						22d. ADDRESS <b>3611 Branch Ave., S.E. Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				23b. DATE THEREOF <b>1/22/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hosp.</b>				23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>	
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr.</b>						25a. REC'D BY REGISTRAR <b>Jan 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Harry W. Penn, Jr., Administrator 6-158755



01130

1170

Prince George's

Newland

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

January 1955

Boy

Jan. 1, 1955

White

Prince George's, Maryland, USA

For Mr. L. J. L.

For Mr. L. J. L.

*Handwritten text, possibly a signature or address, is visible in the center of the page.*

01130

1170

Prince George's

Prince George's

January 1955

Boy

Prince George's, Maryland, USA

Prince George's

Prince George's

Prince George's

Prince George's



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01181

01151

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>31 hours.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> d. STREET ADDRESS <b>1117 49th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby</b> First <b>Boy "B"</b> Middle <b>Graham</b> Last			4. DATE OF DEATH <b>January 19 1966</b> Month <b>January</b> Day <b>19</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Jan. 18, 1966</b>		9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward Leroy Graham</b>					
14. MOTHER'S MAIDEN NAME <b>Fay Marie Salyers</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					
16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Address</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth, neonatal death.</b> <b>776 X</b> DUE TO <b>Twins birth</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>Jan. 18</b> , 19 <b>66</b> , to <b>Jan. 19</b> , 19 <b>66</b> , that <del>we</del> (we) last saw the deceased alive on <b>Jan. 19</b> , 19 <b>66</b> , and that death occurred at <b>12:20</b> pm, from the causes and on the date stated above.							
22a. SIGNATURE <b>Leroy E. Hoeck</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan. 20, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leroy E. Hoeck, M.D.</b>		22d. ADDRESS <b>3611 Branch Ave., S.E. Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>1/22/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hosp.</b>			
23d. LOCATION (City, town or county) <b>Cheverly, Maryland</b>		23e. REC'D BY REGISTRAR <b>Jan 25 1966</b>					
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Administrator</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

<div> <div>6</div> <div>1</div> </div> <div> <div>01182</div> <div>01152</div> </div>											
<div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Prince Georges</div> <div>MARYLAND</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Prince Georges</div> </div> </div>											
<div> <div> <div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Riverdale</div> </div> <div> <div>c. LENGTH OF STAY IN 1b</div> <div>116-1</div> </div> </div> <div> <div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Eugene Leland Memorial Hospital</div> </div> <div> <div>d. STREET ADDRESS</div> <div>4705 Erie St.</div> </div> </div> </div>											
<div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>Tom</div> </div> <div> <div>4. DATE OF DEATH</div> <div>Jan. 3, 1966</div> </div> </div>											
<div> <div> <div>5. SEX</div> <div>Male</div> </div> <div> <div>6. COLOR OR RACE</div> <div>white</div> </div> <div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div> <div> <div>8. DATE OF BIRTH</div> <div>2-11-87</div> </div> <div> <div>9. AGE (In years last birthday)</div> <div>78 yrs.</div> </div> <div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>Min.</div> </div> </div>											
<div> <div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>retired from US Dept. of Agriculture</div> </div> <div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div></div> </div> <div> <div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> <div>Pennsylvania</div> </div> <div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> </div> </div>											
<div> <div> <div>13. FATHER'S NAME</div> <div>William Wallace Graham</div> </div> <div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Mary Catherine White</div> </div> </div>											
<div> <div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div> </div> <div> <div>16. SOCIAL SECURITY NO.</div> <div>214-10-7936A</div> </div> <div> <div>17. INFORMANT</div> <div>Daughter/Medical Record</div> </div> </div>											
<div> <div> <div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</div> <div>Chronic Degenerative Heart Failure</div> <div>442X</div> <div>CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUE TO</div> <div>(b) Chronic Pulmonary Edema</div> <div>DUE TO</div> <div>(c) Arterio-sclerotic Cardio-vascular Stenosis</div> </div> <div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div> </div>											
<div> <div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).</div> </div> <div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div> </div>											
<div> <div> <div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> </div> <div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div> </div>											
<div> <div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m.</div> <div>p.m.</div> <div>19</div> </div> <div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div> <div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> </div> <div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div> </div> </div>											
<div> <div> <div>21. I certify that (I) (this hospital) attended the deceased from 1958, 1930, to Jan 1966, that (I) (we) last saw the deceased alive on Jan 3, 1966, and that death occurred at 10:30 AM, from the causes and on the date stated above.</div> </div> <div> <div>22a. SIGNATURE</div> <div>W. L. Etienne</div> <div>M.D.</div> </div> <div> <div>22b. DATE SIGNED</div> </div> </div>											
<div> <div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>W. L. Etienne, M. D.</div> </div> <div> <div>22d. ADDRESS</div> <div>4713 Berwyn Road, College Park, Md.</div> </div> </div>											
<div> <div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div> <div> <div>23b. DATE THEREOF</div> <div>1/5/66</div> </div> <div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Gate of Heaven</div> </div> <div> <div>23d. LOCATION (City, town or county)</div> <div>Montgomery Co., Md.</div> </div> </div>											
<div> <div> <div>24. FUNERAL DIRECTOR</div> <div>7 Joseph Sano 4138 Balt. Ave Hyattsville, Md.</div> </div> <div> <div>25a. REC'D BY REGISTRAR</div> <div>JAN 7 1966</div> </div> <div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>John Charles Judge</div> </div> </div>											

0118

0118

0118

11/14

11/14

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items 23, 3, 10a, 11, 12, 13, 14, 17, 24 Film G378 6/20/66 mh									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01183 01153									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>					d. STREET ADDRESS <b>6413 Buchanan Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Doris Ann Grantham</b>					4. DATE OF DEATH Month Day Year <b>1 12 19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-30-1941</b>		9. AGE (In years lost birthday) yrs. <b>24</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wash., D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George T. Redmon</b>					14. MOTHER'S MAIDEN NAME <b>Marion Beach</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Vincent Grantham, Same as #2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO <b>Retroperitoneal and peritoneal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Laceration of vagina</b> DUE TO <b>Complicated delivery of twin pregnancy</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>60 hrs</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypofibrinogenemia and necrosis of liver</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Vagina lacerated during delivery.</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Delivery room, Prince George's Hospital</b>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>2:20am 1-10- 19 66</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Delivery room, Prince George's Hospital</b>		20f. (City or town) (County) (State) <b>Prince George's (County) Md.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.					22. DATE SIGNED <b>1-13-66</b>				
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>					Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-15-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Nat'l</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland Md.</b>		
24. FUNERAL DIRECTOR <b>Robert A. Mattingly</b> 131 H St. SE Washington, D.C.					25a. REC'D BY REGISTRAR DATE <b>JAN 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

Two-for-one Film G378 6/20/66 mh

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01184

01154

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>5705 Nome Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Fred Greer</u>		4. DATE OF DEATH Month Day Year <u>1 26 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Aug. 1896</u>
9. AGE (In years lost birthday) yrs. <u>69</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Geer S.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Greer</u>		14. MOTHER'S MAIDEN NAME <u>Anna Greer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Josephine Richardson</u>		Address <u>5705 Nome St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>4200</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-27-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>30 Jan. 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mark Church CEMT.</u>	23d. LOCATION (City or Town) (County) (State) <u>Greenville S.C.</u>
24. FUNERAL DIRECTOR <u>HOFFMAN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>909-6th</u>		DATE <u>FEB 3 1966</u>	



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13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01185 CERTIFICATE OF DEATH 01155

1. PLACE OF DEATH a. COUNTY Prince George's			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 10 days			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 3306 Perry Street				
3. NAME OF DECEASED (Type or print) First Middle Last Lewis Hageage			4. DATE OF DEATH Month Day Year January 27 1966			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/1918		9. AGE (In years last birthday) 67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.		11. BIRTHPLACE (County & State, or foreign country) Tripoli, Syria		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nick Hageage						14. MOTHER'S MAIDEN NAME Sadie ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart & Renal Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1964, to 1/27, 1966, that (I) (we) last saw the deceased alive on 1/27 1966, and that death occurred at 3:35 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Charles C. Hageage						22b. DATE SIGNED 1-27-66				
22c. PHYSICIAN'S NAME (Type) Dr. Charles C. Hageage						22d. ADDRESS 3308 Perry Street, Mt. Rainier, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/31/66		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.				
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.						25a. REC'D BY REGISTRAR DATE FEB 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

2019

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01186

## CERTIFICATE OF DEATH

01156

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>several years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>506 Chillum Road</b>			d. STREET ADDRESS <b>506 Chillum Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Howard I. Hallock</b>			4. DATE OF DEATH Month Day Year <b>Jan. 22, 1966</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/1908</b>		9. AGE (In years last birthday) <b>57</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor FHA Comptroller Div.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brooklyn, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Howard Hallock</b>			14. MOTHER'S MAIDEN NAME <b>Mabel Clark</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes NW 11</b>		16. SOCIAL SECURITY NO. <b>054 05 9797</b>		17. INFORMANT <b>Anna Hallock</b> Address <b>506 Chillum Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>2043</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE LEUKEMIA</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>4 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DERMATOMYOSITIS</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959, 19</b> , to <b>JAN 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>1-22</b> 19 <b>66</b> , and that death occurred at <b>4:38 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>H. Tanenbaum</b>			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Herbert L. TANENBAUM</b>
22d. ADDRESS <b>4400 Conn. Ave NW WASH DC</b>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>	
23d. LOCATION (City or Town) <b>Chestertown, Md.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #9 Film #G373 2/2/66 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01187						01157					
1. PLACE OF DEATH a. COUNTY Prince Georges						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY PG					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General						d. STREET ADDRESS 3112 Bellevue Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beatrice			First Middle Last Hardesty			4. DATE OF DEATH 1 12 19 66					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/09		9. AGE (In years last birthday) 56 2/3 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Elmer Nelson						14. MOTHER'S MAIDEN NAME Alma Leonard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Alma Broy Cheverly, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Generalized Carcinomatous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-2-65 to 1-12, 1966, that (I) (we) last saw the deceased alive on 1-12 1966, and that death occurred at 10:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE A Deitz						ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-13-66			
22c. PHYSICIAN'S NAME (Type) Dr. Aaron Deitz						22d. ADDRESS Prince Geo. Plaza, Hyattsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan 17, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JAN 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

7010

22901



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

01188

01158

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. STREET ADDRESS <u>741 60th. Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Hatcher</u> Last <u>Hatcher</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1914</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>51</u> Days <u>10</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>unknown</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1-10-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Jan 14, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace, VA</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>Brown &amp; Camille</u>		25a. REC'D BY REGISTRAR <u>13 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

01128

01742 10/10/50

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10/10/50



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01189

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02689

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home-Same as #2</u>		d. STREET ADDRESS <u>Apt 12, 3528 Silver Hill Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Howard</u> Last <u>Henderson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Oct, 1922</u> 43
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>British Embassy</u>	
11. BIRTHPLACE (State or foreign country) <u>Knoxville, Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl A. Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Janettie Childress</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Helen C. Henderson -7700- Alpine St.</u>		Address <u>SE.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns-100% of body surface</u> 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trapped in burning apartment</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-29 p.m.</u> 19 <u>65</u>	20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Same as #2</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale</u>		22. DATE SIGNED <u>2-5-65</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 11th 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Knoxville, Tenn.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1966</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros. 1661- Good Hope Road SE. Wash. DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01150

01159

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Coral Hills Cheverly</b> c. LENGTH OF STAY IN 1b <b>Coral Hills Cheverly</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges Co, Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Coral Hills, Maryland 16-1</b> d. STREET ADDRESS <b>5309 P Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>P.</b> Last <b>HERRMANN</b>			4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>1966</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Cauc.</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>5-7-94</b>		
9. AGE (In years last birthday) <b>71</b> yrs.			10. FINDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Outdoor Advertising</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>			12. CITIZEN OF WHAT COUNTRY? <b>US OF A</b>		
13. FATHER'S NAME <b>Ben Herrmann</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16. SOCIAL SECURITY NO. <b>WW I 578-09-1235</b>		
17. INFORMANT <b>Nellie E Herrmann</b>			Address <b>same as 2d</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Chronic Cardio Vascular</b> <b>Reformed Arteriosclerosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1 Jan</b> , 19 <b>66</b> , to <b>19 Jan</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19 Jan</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert C Haile</b>			22b. DATE SIGNED <b>1/24/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>ROBERT C. HAILE</b>			22d. ADDRESS <b>35 Myrae NW</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan 27, 66</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR <b>Lee Funeral Home, 300 4th NE, Wash, DC</b>			25a. REC'D BY REGISTRAR <b>JAN 26 1966</b>		
			25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>		

01150

01160

STATE OF TEXAS

THE STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE STATE OF TEXAS

IN AND FOR THE COUNTY OF DALLAS

THE STATE OF TEXAS

VS.

JOHN A. BROWN

Defendant

vs.

THE STATE OF TEXAS

Plaintiff

vs.

THE STATE OF TEXAS

Plaintiff

vs.

THE STATE OF TEXAS

Plaintiff

vs.

THE STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01191

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01160

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>5 Mo. 8 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C. 47-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suitland Nursing Home Inc.</b>			d. STREET ADDRESS <b>311 C Street, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Maud L Hines</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>19</b> Year <b>1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 8, 1879</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Anderson Overholtz</b>		
14. MOTHER'S MAIDEN NAME <b>Kate McDonald</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>--</b>			17. INFORMANT <b>Mary Howell</b> Address <b>5431 16th Av-Hyattsville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4221</b> DUE TO (c) <b>4221</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-12</b> , 1965, to <b>1-19</b> , 1966, that (I) (we) last saw the deceased alive on <b>1-16</b> , 1966, and that death occurred at <b>9:30</b> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <b>John F. Shay</b>			22b. DATE SIGNED <b>1-19-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>John F. Shay</b>			22d. ADDRESS <b>5203 Silver Hill Rd, Suitland, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/22/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>	
23d. LOCATION (City, town or county) <b>Front Royal, Va.</b>		23e. REC'D BY REGISTRAR <b>JAN 21 1966</b>		23f. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Jas. T. Ryan, Inc.</b>		24b. ADDRESS <b>317 Pa. Ave., SE DC3</b>		24c. DATE <b>JAN 21 1966</b>	



01110

01110

James H. Goff

England

James H. Goff

Hand

2025 RELEASE DATE 08-10-2025

John P. Goff

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01192						01161					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>PRINCE GEO. CO.</u> MARYLAND						a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4068 WARNER AVE.</u>						d. STREET ADDRESS <u>4068 WARNER AVE.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<u>HELEN</u>			<u>HOWARD</u>			<u>JAN. 5TH</u>			<u>1966</u>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
<u>FEMALE</u>	<u>WHITE</u>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>MAR. 27, 1881</u>	<u>84</u> yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<u>HOUSEWIFE</u>						<u>WASHINGTON, D.C.</u>			<u>U.S.</u>		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<u>JACOB FUCHS</u>						<u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
<u>NO</u>				<u>NONE</u>		<u>MRS RUTH E. BAKER</u>			<u>SAME AS # 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>4200</u> DUE TO <u>Arterio Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Senescent Arterio Sclerosis</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 20</u> , 19 <u>60</u> to <u>Jan 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 3</u> - 19 <u>66</u> , and that death occurred at <u>11:54 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>E. Stuart Lyddane</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>1/5/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. STUART LYDDANE</u>						22d. ADDRESS <u>3066 Que St. N.W. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>BURIAL</u>			<u>Jan 7, 1966</u>		<u>ARLINGTON NATIONAL</u>			<u>ARLINGTON, VIRGINIA</u>			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>W.W. CHAMBERS CO.</u>						<u>RIVERDALE MD</u>		<u>JAN 10 1966</u>		<u>Charles Judge</u>	

MEDICAL CERTIFICATION

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01193

01162

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 207 Patuxent Road				d. STREET ADDRESS 207 Patuxent Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise		Middle Woodward		Last Hurtt		4. DATE OF DEATH Month 1 Day 11 Year 19 66	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-11	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Richmond Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stewart M. Woodward				14. MOTHER'S MAIDEN NAME Ina T. Trail			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Charles D. Hurtt Address 207 Patuxent Rd Laurel Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9160 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Fire in home DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in burning house					
20c. TIME OF INJURY Month, Day, Year 3:50 a.m. p.m. 1 11 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 1-12-65	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 1-14-66		23c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery		23d. LOCATION (City, town or county) (State) Richmond Va.	
24. FUNERAL DIRECTOR De Witt Canalehan, Laurel, Md.				25a. REC'D BY REGISTRAR DATE JAN 19 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5319

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
011194		Item #2 Film #G373		2/1/66		01163					
1. PLACE OF DEATH a. COUNTY Prince George XXXXXXXX MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geor.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS Suitland Nursing Home - 1					
3. NAME OF DECEASED (Type or print) Robert C. Hyman						4. DATE OF DEATH Jan. 20 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-1887		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Plumber		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Saul Hyman						14. MOTHER'S MAIDEN NAME Anny Taylor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-14-2784		17. INFORMANT Seat Pleasant, Md. Mary A. Hyman 7101 Rollin Ridge					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Acute cerebral insufficiency DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 20, 19 66 to Jan 20, 19 66 that (I) (we) last saw the deceased alive on Jan 19, 19 66, and that death occurred at 4:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Peter Duus						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/21/66	
22c. PHYSICIAN'S NAME (Type) Peter Duus						22d. ADDRESS 6124 Central Ave., Capitol Height, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-66		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) Prince George, Md.					
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS 300 4th St. N.E. Washington, D.C.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge					
				DATE JAN 25 1966							



01103

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6132 Central Ave., Federal Heights, Mo.

Later Date





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01196					01165				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY		PRINCE GEORGES			a. STATE		MARYLAND		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		HYATTSVILLE, P.O.			b. COUNTY		PRINCE GEORGES		
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		HYATTSVILLE P.O. 16-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
404 CHILLUM RD - Apt #102					404 CHILLUM RD Apt #102				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
LOLA FRANCES JAMES					JAN. 30 19 66				
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12-23-1902		63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY		IF UNDER 1 YEAR	
HOUSE WIFE		AT HOME		VA		U.S.A		Days Hours Min.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
DAVID L CUMMINGS					ELIZABETH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		Unknown		Wm V James		2702 Wisconsin Ave NW, Apt 6 Washington D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4200									
DUE TO (b) Congestive Heart Failure									
DUE TO (c) Arterio-sclerotic Heart Disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from April 19 66, to Jan - 30, 19 66, that (I) (we) last saw the deceased alive on Jan 2 19 66, and that death occurred at 9:45 P.M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
E. STUART LYDDANE					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
E. STUART LYDDANE					3066 - QUE ST. N.W. WASH DC.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		FEB 3 - 1966		Union Cemetery		Leesburg Va.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR				
W.W. CHAMBERS Co. Inc - WASH. D.C.					FEB 4 1966				
					25b. REGISTRAR'S SIGNATURE				
					Charles Judge				

01163

01163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01197					01166				
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> d. STREET ADDRESS <b>2915 Ritchie Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Gladyce</b>		First		Middle		Last		4. DATE OF DEATH <b>January 3 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/29/20</b>		9. AGE (In years last birthday) <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Walter Bristow</b>				14. MOTHER'S MAIDEN NAME <b>Ruby -</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>4331</b>		17. INFORMANT <b>Leon J. Johnson</b> Address <b>SAME AS 2 D</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerotic Stutter</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>IV</b> (this hospital) attended the deceased from <b>Dec. 26 1965</b> to <b>Jan. 3 1966</b> , that <b>we</b> last saw the deceased alive on <b>Jan 3 19 66</b> , and that death occurred at <b>10:50 am</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Carolina Paredes Manlapaz, M.D.</b>				22b. DATE SIGNED <b>1-3-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Carolina Paredes Manlapaz, MD</b>				22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1-7-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Va Md.</b>			
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons 4925 Kleeve Ave NE</b>				25a. REC'D BY REGISTRAR <b>JAN 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

0110

CENTRAL BANK OF GEORGIA

0110

Princess George's

Harvard

Princess George's

Forrestville

8 days

Chester

12th Street, Wood

Princess George's Hospital

1st January

London

Albany

12th Street

12th Street

12th Street

12th Street

Water Street

July -

12th Street

12th Street

12th Street

12th Street

12th Street

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12th Street

12th Street, 12th Street, 12th Street



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

01198

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01167

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>16-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital Rt. 1 Box 1810</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kevin W. Johnson</u>			4. DATE OF DEATH <u>Jan. 19 1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Color</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-65</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Jerome Johnson</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jerome Johnson</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Hydrocephalus</u> <u>752X</u> DUE TO <u>Convulsions, cause undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>asphyxiation</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19 1966</u> , to <u>Jan. 19 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19 1966</u> , and that death occurred at <u>7p.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Leroy E. Hoeck</u>				22b. DATE SIGNED <u>Jan. 20, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Leroy E. Hoeck, M.D.</u>	
22d. ADDRESS <u>3611 Branch Ave., S.E. Washington, D.C.</u>				22e. REC'D BY REGISTRAR <u>James Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-24-66</u>				23b. DATE THEREOF <u>1-24-66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Family Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Woodmore Md</u>			
24. FUNERAL DIRECTOR <u>A.S. Washington &amp; Sons 4925 Dennc Ave NW</u>				25a. REC'D BY REGISTRAR <u>JAN 25 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>				25c. DATE <u>5-153366</u>			



0110

0110

Jan. 20, 1964

1011 Broadway Ave., N.E. Washington, D.C.

Jan. 20, 1964

1  
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

61199

01168

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. LENGTH OF STAY IN 1b <b>7 mos., 25 dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>1315 South Carolina Ave. SE.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William R. Johnson</b>				4. DATE OF DEATH Month Day Year <b>Jan. 23 19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/27/1868</b>	
9. AGE (In years last birthday) <b>97</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>King George Co., Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Aaron Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lacy</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Decedent</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intraperitoneal hemorrhage</b> 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the liver</b> (c) <b>Post-necrotic cirrhosis of the liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease with congestive heart failure, generalized arteriosclerosis; bilateral inguinal herniae</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/28 1965</b> to <b>1/23 1966</b> , that (I) (we) last saw the deceased alive on <b>1/23 1966</b> , and that death occurred at <b>3:55 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b>				22b. DATE SIGNED <b>1/23/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-26-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>Phonola 3015-12 St. TE</b>				25a. REC'D BY REGISTRAR <b>JAN 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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John (son)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>1</div> <div> <div>MD</div> <div>01200</div> </div> <div> <div>01169</div> </div>											
<div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> </div> <div> <div>5</div> <div>6</div> </div> <div> <div>7</div> <div>8</div> </div> <div> <div>9</div> <div>10</div> </div> <div> <div>11</div> <div>12</div> </div>											
<div>1. PLACE OF DEATH</div> <div> <div>a. COUNTY</div> <div>Prince George's</div> </div> <div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Hyattsville</div> </div> <div> <div>c. LENGTH OF STAY IN ID</div> <div>7 wks</div> </div> <div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Hyattsville Nursing Home</div> </div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div> <div>a. STATE</div> <div>Maryland</div> </div> <div> <div>b. COUNTY</div> <div>Montgomery</div> </div> <div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Washington / Silver Spring</div> </div> <div> <div>d. STREET ADDRESS</div> <div>9910 Mass. Avenue</div> </div> <div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>					
<div>3. NAME OF DECEASED (Type or print)</div> <div>Alice Johnston</div>						<div>4. DATE OF DEATH</div> <div>Jan 3 1966</div>					
<div>5. SEX</div> <div>F</div>		<div>6. COLOR OR RACE</div> <div>W</div>		<div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>Feb. 14, 1885</div>		<div>9. AGE (In years last birthday)</div> <div>80 yrs.</div>		<div>10. IF UNDER 1 YEAR IF UNDER 24 HRS.</div> <div>Months Days Hours Min.</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Speech Therapist</div>						<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>State Teachers College</div>		<div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> <div>Georgia, Ill</div>		<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>	
<div>13. FATHER'S NAME</div> <div>George Johnston</div>						<div>14. MOTHER'S MAIDEN NAME</div> <div>Mary Gill</div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>None</div>				<div>16. SOCIAL SECURITY NO.</div> <div>Yes</div>		<div>17. INFORMANT</div> <div>Cave Johnston</div>				<div>Address</div> <div>9910 Mass. Avenue Silver Spring, Maryland</div>	
<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>4500</div> <div>DUE TO</div> <div>Respiratory arrest</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>Cerebral Vascular insufficiency</div> <div>DUE TO</div> <div>(c)</div> <div>Cerebral arteriosclerosis</div> </div>										<div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>min.</div>	
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>malnutrition</div>										<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div>							
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div>				<div>20d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not While <input type="checkbox"/></div> <div>at work at work</div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town) (County) (State)</div>			
<div>21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1965, to Jan 3, 1966, that (I) (we) last saw the deceased alive on December 27, 1965, and that death occurred at 5 AM, from the causes and on the date stated above.</div>											
<div>22a. SIGNATURE</div> <div>Harold W. Draper</div>						<div>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div>		<div>22b. DATE SIGNED</div> <div>Jan 3, 1966</div>			
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>Harold W. Draper</div>						<div>22d. ADDRESS</div> <div>10620 Georgia Ave, Silver Spring</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Cremation</div>		<div>23b. DATE THEREOF</div> <div>1-3-66</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Fort Lincoln Crematory</div>		<div>23d. LOCATION (City, town or county) (State)</div> <div>Prince Georges Co., Maryland</div>					
<div>24. FUNERAL DIRECTOR</div> <div>Clark E. Evans</div>						<div>ADDRESS</div> <div>4434 Georgia Avenue</div>		<div>25a. REC'D BY REGISTRAR</div> <div>Charles Judge</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>	
<div>Warner E. Dumphreys, Inc.</div>						<div>Silver Spring, Md.</div>		<div>DATE</div> <div>JAN 6 1966</div>		<div></div>	

0318

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01170

FOR STATE  
HEALTH DEPT.

M 01201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 hours</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5800 Oakes Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George</b>		4. DATE OF DEATH Month <b>1</b> Day <b>20</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-16-1915</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>20</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work, and during most of working life, even if retired) <b>Helper - Truck</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood Stores</b>	
11. BIRTHPLACE (State or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Jones</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>Ella Jones</b>	
17. INFORMANT <b>Same as 2d above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>From Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Inactive Pulmonary TB - over 2 yrs. 0022</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kenoe</b>		22. DATE SIGNED <b>1-21-66</b>	
EXAMINER'S NAME (Type) <b>John Kenoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Jan. 24, 1966</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Highland Park Md.</b>	
24. FUNERAL DIRECTOR <b>Henry S. Washington &amp; Sons Inc. N.E.</b>		25a. REC'D BY REGISTRAR <b>JAN 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John S. Judge</b>			

01170



01202

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6 1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01203

01171

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
c. LENGTH OF STAY IN 1b <u>24 years</u>				d. STREET ADDRESS <u>42 Arandale St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES WILBERT KAISER</u>				4. DATE OF DEATH <u>January 26 1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 11 1898</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own garage</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Laurel Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CHARLES KAISER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH GREEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>ROBERT KAISER, LAUREL MD</u>			
17. INFORMANT <u>ROBERT KAISER, LAUREL MD</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1969</u> DUE TO <u>Generalized Osteolytic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Plasma Cell Myeloma</u> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>Jun 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jun 26 1966</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>Robert C. Wingfield</u> M.D.			
22b. DATE SIGNED <u>Jun 26, 1966</u>				22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>			
22d. ADDRESS <u>Laurel Md.</u>				22e. REC'D BY REGISTRAR <u>FEB 3 1966</u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>1-29-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cem.</u>			
23d. LOCATION (City, town or county) (State) <u>Laurel Md.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Darnedman</u> ADDRESS <u>Laurel Md</u>			

01110

01110

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "James" and "Harris" are faintly visible.]*

271  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01204

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01172

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN ID <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital, Cheverly</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>California</b> b. COUNTY <b>San Francisco</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>43-3</b> d. STREET ADDRESS <b>1755 Van Ness Ave., Apt 105</b>			
3. NAME OF DECEASED (Type or print) <b>Paul Erhardt Kallerup</b>				4. DATE OF DEATH Month Day Year <b>January 22, 1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1915</b>	
9. AGE (In years last birthday) <b>50 yrs.</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Erhardt Kallerup</b>				14. MOTHER'S MAIDEN NAME <b>Ingerborg Langeberg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.II</b>				16. SOCIAL SECURITY NO. <b>567-01-9352</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion, Left Anterior Descending</b> DUE TO (c) <b>Coronary Arteriosclerotic Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, MD.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Golden Gate National</b>		23d. LOCATION (City, town or county) (State) <b>San Bruno, Calif.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				25a. REC'D BY REGISTRAR <b>4739 Bait. Ave, Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>1/25/66</b>	

01178

01204

THE STATE  
HEALTH DEPT.

California

George's

San Francisco

Geography

George's on the Medical, University

Paul, Ernest, California

Note: White, June 28, 1935

George's on the Medical, University

George's on the Medical, University

George's on the Medical, University

None

X

George's, M.

George's, M.



01205

Item #9 Film #3375 2/10/66 pc

CERTIFICATE OF DEATH

Reg. Dist. No.

01173

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>COLMAR MANOR</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colmar Manor</i> 16-10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3607-43 Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Leon</i> Middle <i>M</i> Last <i>Kane</i>				4. DATE OF DEATH Month <i>January</i> Day <i>28</i> Year <i>1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>28 March 1931</i>	
9. AGE (In years last birthday) <i>34</i>		10. IF UNDER 1 YEAR Months <i>12</i> Days <i>15</i> Hours <i>15</i> Min.		11. BIRTHPLACE (State or foreign country) <i>TEXAS</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Comptroller General G.H.O.-U.S.G.</i>				11. BIRTHPLACE (State or foreign country) <i>TEXAS</i>			
13. FATHER'S NAME <i>James Mac Murray</i>				14. MOTHER'S MAIDEN NAME <i>Rachael Raviell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-32-4315</i>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				18. INFORMANT <i>Nora Lee Kane</i> Address <i>1500 Arlington Blvd. Arlington Va.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> 287 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive cardiovascular disease years</i> DUE TO (c) <i>Excessive obesity</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Interval between onset and death</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>52</i> to <i>28 Jan</i> , 19 <i>66</i> that I last saw the deceased alive on <i>27 January</i> , 19 <i>66</i> and that death occurred at <i>8:20 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Thomas E. Mattingly, M.D.</i>				DATE SIGNED <i>Feb. 28, 1966</i>			
PHYSICIAN'S NAME (Type) <i>Thomas E. Mattingly, M.D.</i>				(20018) <i>June 6</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 31, 1966</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			



11119

CERTIFICATE OF DEATH

11119

Blank certificate form with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01206						01174					
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE 16-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nurs. Home Lanham, Md.</u>						d. STREET ADDRESS <u>3900 53RD PLACE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Maizie CHRISTINE Kether</u>			4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1966</u>								
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24 1885</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Huron H. Huyett</u>						14. MOTHER'S MAIDEN NAME <u>Lydia Shupp</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. JANE FERRELL</u> Address <u>HYATTSVILLE MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>Severe anemia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 wk.</u> <u>10 yrs.</u> <u>4 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary insufficiency. Diverticulitis-hemorrhagic</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4-10</u> , 19 <u>63</u> , to <u>1-24</u> , 19 <u>66</u> , that <u>(we)</u> last saw the deceased alive on <u>1-26</u> , 19 <u>66</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>R.D. Bauer M.D.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-29-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, M.D.</u>						22d. ADDRESS <u>2513 Buck Lodge Rd. Cataphract, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/31/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Anne Hall</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>					
24. FUNERAL DIRECTOR <u>W.T. Harshbarger</u>						ADDRESS <u>Hag. Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	

01738

01738



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01175

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>16-1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>7647 Greenleaf Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leslie Paul Kelly</b>				4. DATE OF DEATH Month Day Year <b>1 26 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-1906</b>		9. AGE (In years lost birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas J Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Edna E Mc Neil</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Dolores A Garner Hyattsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3442</b> IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>From inability to cough</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>From paralysis of intercostal muscles</b> DUE TO <b>From meningitis</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>44 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <b>1-27-66</b>
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

01175

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01208

01176

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges County</u> <span style="float: right;"><u>MARYLAND</u></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u> <span style="float: right;">c. LENGTH OF STAY in 1b <u>6 yrs</u></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Albany, N.Y.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>318 State Street</u> <span style="float: right;"><u>69-3</u></span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna Marie Lanahan</u>		<b>4. DATE OF DEATH</b> Month <u>1-</u> Day <u>2-</u> Year <u>19 66</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept. 15, 1879</u>		<b>9. AGE</b> (In years last birthday) <u>86</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Albany, N.Y.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Thomas J. Lanahan</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen M. Powers</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Sacred Heart Home Records</u> Address <u>  </u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 days</u>  <u>6 Yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (his hospital) attended the deceased from <u>1-13</u> to <u>Jan. 2, 1966</u>, that (I) (we) last saw the deceased alive on <u>Jan. 1, 1966</u>, and that death occurred at <u>8:25 PM</u> from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Thomas F. Collins</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>1-3-66</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Thomas F. Collins</u>						<b>22d. ADDRESS</b> <u>322 H. St., N.E., Wash., D.C.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>1-4-66</u>		<b>23c. NAME OF CEMETERY</b> <u>St. Agnes</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Albany, New York</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. J. Collins</u> ADDRESS <u>3821-14th St NW Wash DC</u>						<b>25a. REC'D BY REGISTRAR</b> <u>JAN 6 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01118

CENTRICITY OF BEATH

01208

1. LINE NOT TO CORRECTION

2. LINE NOT TO CORRECTION

3. LINE NOT TO CORRECTION

4. LINE NOT TO CORRECTION

5. LINE NOT TO CORRECTION

6. LINE NOT TO CORRECTION

7. LINE NOT TO CORRECTION

JOHN H. FOSTER

JOHN H. FOSTER

JOHN H. FOSTER

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JOHN H. FOSTER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Item 18 Film G373 2/2 Maryland State Department of Health  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item #9 Film #G373 2/2/66

01209

01177

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md.		b. COUNTY Prince Geo Co	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leesdale		c. LENGTH OF STAY IN 1b usual residence		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leesdale 16-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7106 23rd Avenue		d. STREET ADDRESS 7106 23rd Ave		4. DATE OF DEATH Jan 22 1966		Month Day Year	
3. NAME OF DECEASED (Type or print) ALBERT SYDNEY LAWRENCE		First Middle Last		4. DATE OF DEATH Jan 22 1966		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1892	
9. AGE (in years less birthday) 74 1/2 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Tank Salesman		10b. KIND OF BUSINESS OR INDUSTRY Esso Oil		11. BIRTHPLACE (County & State, or foreign country) Saint Marys Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Joseph A. Lawrence		14. MOTHER'S MAIDEN NAME Susan Cullison		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard F. Lawrence (Same as #2)		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163x DUE TO Lungenia (b) Carcinoma of Lungs (c) Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 20 1965 to DEC. 10 1965, that (I) (we) last saw the deceased alive on DEC. 10 1965, and that death occurred at 4:30 PM, from the causes and on the date stated above.		22a. SIGNATURE C. EDWIN McNAMARA M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/23/66	
22c. PHYSICIAN'S NAME (Type) C. Edwin McNamara		22d. ADDRESS 1801 G St NW Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 26, 1966		23c. NAME OF CEMETERY OR CREMATORY Mount Pleasant Cemetery		23d. LOCATION (City, town or county) Washington DC	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		ADDRESS 254 Carroll St NW DC		25a. REC'D BY REGISTRAR JAN 26 1966		25b. REGISTRAR'S SIGNATURE	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01210

01178

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Riverdale</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5419 56th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>JOSEPH</b> Middle <b>LEAHY</b> Last <b>Sr.</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1893</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b>	11. IF UNDER 24 HRS. Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Commander</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Paul</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI WW II</b>		16. SOCIAL SECURITY NO. <b>051 05 0874</b>	
17. INFORMANT <b>Marion A. Leahy</b>		Address <b>Same as #2 (daughter)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>over 5 yr.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1/3/66</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/6/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>JAN 7 1966</b>	
ADDRESS <b>Hyattsville, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01211

CERTIFICATE OF DEATH

01179

Item #9 Film #G372 1/13/60 DC

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>11-20-04</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>			e. STREET ADDRESS <b>301 65th St. Md. Park</b>		
3. NAME OF DECEASED (Type or print) First <b>Tr</b> Middle <b>F.</b> Last <b>Lee</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>2</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Chinese</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-20-04</b>		9. AGE (In years last birthday) <b>61</b> 5/6 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundryman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>		11. BIRTHPLACE (County & State, or foreign country) <b>San Francisco, Cal.</b>	
13. FATHER'S NAME <b>Unk</b>			14. MOTHER'S MAIDEN NAME <b>Unk</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>578-20-2287</b>		17. INFORMANT (Wife) <b>301 65th St. Address</b> <b>Juanita Lee, Maryland Pk, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recent Antero-septal Myocardial infarct</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Recent occlusion of Lt. main stem</b> (c) <b>and ant. Descending br. of Lt. Coronary</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , 19 <b>8</b> , to <b>JAN 2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>JAN 2</b> , 19 <b>66</b> , and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Peter Duus</b>				22b. DATE SIGNED <b>Jan. 2, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter Duus, M. D.</b>				22d. ADDRESS <b>6124 Central Avenue, Capitol Heights, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 5, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat Cem.</b>	
24. FUNERAL DIRECTOR <b>LEE FUNERAL HOME, 300 4TH ST, WASH, DC</b>		23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>		(State)	
25a. REC'D BY REGISTRAR <b>JAN 6 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01150

Prince George

Nov 1940

Best Account

301 East 82 St. Park

Jan

Prince George

Nov 1940

Prince George

Chinese

Male

Jan



Jan 1, 1941

Jan 1, 1941

Jan 1, 1941

Jan 1, 1941

Jan 1, 1941



FOR STATE  
HEALTH DEPT.

01212

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01180

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> <u>16-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>7203 Wilburn Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Wayne Leebrick</u>				4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10 May 1928</u>		9. AGE (In years lost birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u> Hours <u>19</u> Min <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SET PRESSMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK L. LEEBRICK</u>				14. MOTHER'S MAIDEN NAME <u>ELANEE DELONNE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES</u> <u>KOREAN</u>		16. SOCIAL SECURITY NO. <u>578-349178</u>		17. INFORMANT <u>THELMA M LEEBRICK SEAT PLEASANT, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>From occlusion of left coronary artery,</u> anterior descending. (c) <u>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>min.</u>  <u>minutes unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kenoe</u> M.D.				22. DATE SIGNED <u>1-27-66</u>			
EXAMINER'S NAME (Type) <u>John Kenoe, M.D. Riverdale, Md.</u>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co 517 H ST S.E.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03110

7 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> d. STREET ADDRESS <u>Box 278-A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edward Lawrence Leer</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-1-1913</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>52</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.						<b>4. DATE OF DEATH</b> <u>1</u> <u>1</u> <u>19</u> <u>66</u> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shock Crete Corp.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, DC.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>							
<b>13. FATHER'S NAME</b> <u>Harry J. Leer</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Flynn</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Mary Isabelle Leer (Wife)</u> <u>Same as # 2.</u> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lobar pneumonia, left upper lobe</u> DUE TO <u>and surgical resection of right lung, old.</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>John Kehoe</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>1-2-66</u> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>Jan. 4-1966</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Suitland, Maryland.</u> <b>23. FUNERAL DIRECTOR</b> <u>Simmons Bros.</u> ADDRESS <u>1661- Good Hope Rd. SE. Wash., DC</u> <b>24a. REC'D BY REGISTRAR</b> <u>JAN 5 1966</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>													

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11. *Journal of the American Medical Association*, 1997; 277: 1039-1043.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01214

01182

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>				c. LENGTH OF STAY IN ID <b>30 Hours</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suitland Nursing Home, Inc.</b>						d. STREET ADDRESS <b>2715 Terrace Rd., S.E.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Humbert J. Lertora Sr.</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> 20, 19 <b>66</b>			
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8/28/1892</b>	
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>10. UNOER 1 YEAR</b> Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Italy</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Plaster Contractor</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Plaster Contractor</b>		<b>13. FATHER'S NAME</b> <b>Lertora</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Maria Canavaro</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <b>2715 Terrace Rd., S.E.</b>				<b>17. INFORMANT</b> <b>Nora Leortora Wahington, D.C.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b> 4221 DUE TO <b>Metastatic carcinoma of brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACVD.</b> DUE TO (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 months</b> <b>3 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) this hospital attended the deceased from SEPTEMBER 19 65, to 1-20, 1966, that (II) we last saw the deceased alive on 1/19/66 19, and that death occurred on 1/20/66 from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Miguel D. Ruiz M.D.</b>				<b>22b. DATE SIGNED</b> <b>1/20/66</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Miguel Huici</b>	
<b>22d. ADDRESS</b> <b>7250 Livingston Rd., S.E., Oxon Hill, Md</b>				<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Jan. 24-1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Washington, D. C.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Simmons Bros. 1661-Good Hope Rd., SE Wash. DC</b>				<b>25a. REC'D BY REGISTRAR</b> <b>JAN 24 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01182

01212

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01215

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01183

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b>	
c. LENGTH OF STAY IN TB <b>DOA</b>		d. STREET ADDRESS <b>722 60th. Place</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Levi</b>		4. DATE OF DEATH Month Day Year <b>1 8 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Aug. 1939</b>
9. AGE (In years last birthday) yrs. <b>26</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE LEVI, SR.</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH PARKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of chest</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>981X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in chest by assailant</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>1-8- 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Driveway of home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-10-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-14-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON 27, D.C.</b>	
24. FUNERAL DIRECTOR <b>Andrew P. Smith</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	

01183



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in agreement within 72 hours after death.

FOR STATE  
HEALTH DEPT.

01216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01184

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. STREET ADDRESS 7525 Chrisman Avenue	
3. NAME OF DECEASED (Type or print) John Leslie Lewis		4. DATE OF DEATH Jan. 30 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1964
9. AGE (In years) 1 12/10/65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer W. Lewis, Jr.		14. MOTHER'S MAIDEN NAME Delores V. Ballard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Elmer W. Lewsi, Jr. #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3441 IMMEDIATE CAUSE (a) Purulent meningitis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus and spina bifida		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 2-1-66	
EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/66	
23c. NAME OF CEMETERY Fort Lincoln		23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR Jas. T. Ryan, Inc.		25a. REC'D BY REGISTRAR FEB 4 1966	
317 Pa. Ave., SE DC3		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

11-104

RESEARCH IN SCIENCE & TECHNOLOGY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01217					CERTIFICATE OF DEATH					01186				
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville, Md.			c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills Maryland 16-1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forestville Nursing Home					d. STREET ADDRESS 6441- Portal Ave., SE.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John First Middle Last			4. DATE OF DEATH Jan. 29 1966											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29-1871		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Washington Navy Yard			11. BIRTHPLACE (County & State, or foreign country) — Washington, DC.			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Isaac Little					14. MOTHER'S MAIDEN NAME Amy S. Hall									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ethel M. Mason (Dau.) same as # 2.			Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (a) Generalized Atherosclerosis with Circulatory Collapse 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Old Age (c) CHRONIC Cystitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 5 yrs.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from Nov. 5, 1965, to Jan. 29, 1966, that (I) (we) last saw the deceased alive on Jan. 28, 1966, and that death occurred at 5:29 P.M. from the causes and on the date stated above.														
22a. SIGNATURE W.D. Sheer			M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MEO. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-29-66					
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER			22d. ADDRESS 7200 MARLBORO PIKE S.E. WASH. DC.							20028				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 1st 1966		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery			23d. LOCATION (City, town or county) (State) Washington, DC.						
24. FUNERAL DIRECTOR Simmons Bros.			ADDRESS 1661- Good Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR FEB 1 1966		25b. REGISTRAR'S SIGNATURE James Judge							

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People's Republic of China

People's Republic of China

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b MAYLAND	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bugene Leland Memorial Hospital		e. STREET ADDRESS 5715 Emerson St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ola Irene		First Irene		Middle (None)	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-25-22		9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lester Love		14. MOTHER'S MAIDEN NAME Artie Blevens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Medical Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - ovarian Ca - Generalized metastasis 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - ovarian Ca - (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 12/29, 1965, to 1/7, 1966, that (I) (we) last saw the deceased alive on 1/6, 1966, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE R. C. Herman		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-7-66	
22c. PHYSICIAN'S NAME (Type) R. C. Herman, M. D.		22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-66		23c. NAME OF CEMETERY OR CREMATORY Sunset Cemetery	
23d. LOCATION (City, town or county) (State) Berkley, West Virginia		24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR JAN 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JAN 10 1966			

01125

01125

1. Name of the person or organization to whom the property is being transferred

2. Description of the property being transferred

3. Date of the transfer

4. Signature of the person or organization transferring the property

5. Signature of the person or organization receiving the property

6. Date of the signature

7. Address of the person or organization receiving the property

8. Address of the person or organization transferring the property

9. Address of the person or organization receiving the property

10. Address of the person or organization transferring the property

11. Address of the person or organization receiving the property

12. Address of the person or organization transferring the property

13. Address of the person or organization receiving the property

14. Address of the person or organization transferring the property

15. Address of the person or organization receiving the property

16. Address of the person or organization transferring the property

17. Address of the person or organization receiving the property

18. Address of the person or organization transferring the property

19. Address of the person or organization receiving the property

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21. Address of the person or organization receiving the property

22. Address of the person or organization transferring the property

23. Address of the person or organization receiving the property

24. Address of the person or organization transferring the property

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28. Address of the person or organization transferring the property

29. Address of the person or organization receiving the property

30. Address of the person or organization transferring the property

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>16 hr. 52 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b> d. STREET ADDRESS <b>7801 Atwood St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Baby</b>			First <b>Boy</b>			Last <b>Lucia</b>			4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1966</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/28/66</b>		9. AGE (In years last birthday) Months <b>16</b> Days <b>16</b> Hours <b>52</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Donald Emmett Lucia</b>			
14. MOTHER'S MAIDEN NAME <b>Ella Theresa Jarvis</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>--</b>			
17. INFORMANT <b>Address</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyaline membrane disease</b> <b>7615</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Immaturity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Breech presentation</b>				INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Washington, D.C.</b>				20g. (County) <b>District of Columbia</b>				20h. (State) <b>D.C.</b>			
21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>Jan. 28</b> , 19 <b>66</b> , to <b>Jan. 29</b> , 19 <b>66</b> , that <del>we</del> (we) last saw the deceased alive on <b>Jan. 29</b> , 19 <b>66</b> , and that death occurred at <b>2:30M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Leroy E. Hoeck</b>						M.D. <b>Leroy E. Hoeck, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/3/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leroy E. Hoeck, M.D.</b>						22d. ADDRESS <b>3611 Branch Ave. Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				23b. DATE THEREOF <b>2/12/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hosp.</b>			
23d. LOCATION (City, town or county) <b>Cheverly, Maryland</b>				23e. REC'D BY REGISTRAR <b>William A. Parker</b>				23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
24. FUNERAL DIRECTOR <b>William A. Parker, Assistant Administrator</b>											

6-158978



02705

Prince George's

Weymouth

Prince George's

Director's Office

10 hr. 30 min.

Chesley

YB1 ATWOOD ST.

Prince Georges General Hospital

January 22 1955

Lucia

Boy

Baby

11/2/55

White

Male

Prince Georges, Weymouth

Elia Thomas Jarvis

Donald Thomas Jarvis

NO

Jan. 12 1955

Jan. 12

Jan. 12

1/12/55

xxx

1511 Branch Ave. Washington, D.C.

Harry E. Beck, M.D.

1955

TO HOSPITAL death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
01220					01187							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY <i>Prince George's County</i> MARYLAND					a. STATE <i>D.C.</i> b. COUNTY <i>Arundel</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
<i>Washington D.C.</i>					<i>WASHINGTON D.C.</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS							
<i>CARROLL MANOR 4922 WASH. RD N.Y.T.S. MD</i>					<i>De La Salle College</i>							
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH							
First Middle Last					Month Day Year							
<i>BROTHER AZADES GABRIEL MAHER</i>					<i>JAN. 3 1966</i>							
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)				
<i>M</i>		<i>W</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Aug 24, 1884</i>		<i>81 yrs.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
<i>Religious</i>			<i>—</i>			<i>New York</i>			<i>U.S.A.</i>			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
<i>PETER MAHER</i>					<i>UNK.</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
							<i>SP. AGNES CARROLL MANOR</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Uraemia</i>										<i>2 weeks</i>		
4500 DUE TO												
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.												
(b) <i>Generalized arterio-sclerosis</i>										<i>3 years</i>		
DUE TO												
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Month, Day, Year			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
Hour a.m. p.m.												
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1962</i> to <i>Jan. 3, 1966</i> , that (I) ( <i>was</i> ) last saw the deceased alive on <i>Jan. 3, 1966</i> , and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above.												
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
<i>Frank R. Shea</i>					M.D.		<i>1/3/66</i>					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS							
<i>FRANK R. SHEA</i>					<i>4100 - 22nd N.E. WASH. D.C.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)			(State)	
<i>Burial</i>			<i>Jan 7, 1966</i>		<i>St. Joseph's Cemetery</i>			<i>Baltimore</i>			<i>M. Y.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<i>W. L. Taltrow</i>					<i>3603 14th St N.W.</i>		<i>JAN 6 1966</i>					
					<i>ISC 20010</i>		<i>Charles Judge</i>					

MEDICAL CERTIFICATION

5611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>01221</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>01188</span> </div> <div style="text-align: center;">             DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery Co</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> c. LENGTH OF STAY IN 1b <u>2 1/2 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PAINT BRANCH NURSING HOME</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>4509 Romlon St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Ernest Byron Marshall</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>JAN. 3 1966</u>								
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-29-1890</u>		<b>9. AGE</b> (In years last birthday) <u>75 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Taxidermist</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gude's NURSERY-MAN</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>GEORGE MARSHALL</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>KATHY M McNULTY</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT</b> Address <u>MRS Georgia Bond, Same as #2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO (b) <u>Arteriosclerotic &amp; hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Phlebotomy</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hr.</u> <u>10/8.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12-29</u> , 19 <u>65</u> , to <u>1-3</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <u>12-29</u> , 19 <u>65</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>R.D. Bauer M.D.</u>						<b>22b. DATE SIGNED</b> <u>1-3-66</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>R.D. Bauer, M.D.</u>						<b>22d. ADDRESS</b> <u>2513 Buck Lodge Rd. Adelphi, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>			<b>23b. DATE THEREOF</b> <u>JAN 5, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>IVY HILL CEMETERY</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>LAUREL, MD</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Harold S Wade, 550 Wash Blvd, Landover, Md</u>						<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> DATE <u>JAN 4 1966</u> <u>Charles Judge</u>					

01188

RECEIVED

1910

Very much improved  
at 10:15 AM  
The patient  
is now  
The patient  
is now  
The patient  
is now

Very much improved  
at 10:15 AM  
The patient  
is now  
The patient  
is now  
The patient  
is now

Very much improved  
at 10:15 AM  
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is now  
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Very much improved  
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Very much improved  
at 10:15 AM  
The patient  
is now  
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The patient  
is now

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>1</b>            DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  <b>01222</b> </div>													
<div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>6 Hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB, MD.</b> d. STREET ADDRESS <b>WAF BARRACKS BLDG # 1655</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>HOPE</b> First <b>(NMN)</b> Middle Last <b>MATTHEWS</b>						<b>4. DATE OF DEATH</b> Month <b>JAN</b> Day <b>23</b> Year <b>1966</b>							
<b>5. SEX</b> <b>Fe</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDDED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>23 Jan 66</b>		<b>9. AGE (In years last birthday)</b> yrs. <b>6</b> Months <b>13</b> Days <b>13</b>		<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>N/A</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>N/A</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USAF Hospital Andrews Prince George's County</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>			
<b>13. FATHER'S NAME</b> <b>ROY D. MATTHEWS</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>HARRIET L. RODDY</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>N/A</b>		<b>17. INFORMANT</b> <b>MOTHER</b> Address <b>WAF BARRACKS BLDG # 1655 ANDREWS AFB, WASH D.C. 20331</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>7625</b> IMMEDIATE CAUSE (a) <b>Prematurity, Anoxia</b> (b) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 hrs 13 min</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)												<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 23, 1966, to Jan 23, 1966, that (I) (we) last saw the deceased alive on Jan 23, 1966, and that death occurred at 7:00 PM, from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>Phillip Steiner</b>						<b>22b. DATE SIGNED</b> <b>Jan. 23, 1966</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>PHILLIP STEINER</b>						<b>22d. ADDRESS</b> <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>CREMATION</b>				<b>23b. DATE THEREOF</b> <b>24 Jan 66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>D. C. MORGUE</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>WASHINGTON, D.C.</b>					
<b>24. FUNERAL DIRECTOR</b> <b>Carl A. Oufrecht</b>						<b>25a. REC'D BY REGISTRAR</b> <b>FEB 2 1966</b>						<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	



0110

9999

PLATTING

2000

NOTATION



VR A15 (4)  
2DM 1/65

A15 (4)  
1/65

01223

01190

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>16 - 1</b>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>502 9th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Mckinley Matthews</b>		4. DATE OF DEATH <b>Jan. 18, 1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince Geo. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Matthews</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Gertrude Matthews: Item # 2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> 4201 OUE TO (b) <b>Atherosclerosis</b> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>10 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Eg: nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from <b>Jan, 1955</b> , to <b>Jan 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 12 1966</b> , and that death occurred at <b>1 A.M.</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>James H. Weaver, Jr.</b>		22b. DATE SIGNED <b>Jan 18, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert L. Snowden</b>		22d. ADDRESS <b>Rockville, Md</b>		22e. REC'D BY REGISTRAR <b>Jan 21 1966</b>	
23a. BURIAL, CREMATION, REMOVALS (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-21-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Queens Chapel,</b>		23d. LOCATION (City, town or county) (State) <b>Murkirk, Md.</b>		25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00110

STATE OF DEATH

13321

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Manner of death: [illegible]  
6. Signature of physician: [illegible]  
7. Signature of medical examiner: [illegible]  
8. Signature of coroner: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of filing: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Relationship to deceased: [illegible]  
14. Date of interview: [illegible]  
15. Signature of informant: [illegible]  
16. Signature of registrar: [illegible]  
17. Date of filing: [illegible]

18. Name of registrar: [illegible]  
19. Address of registrar: [illegible]  
20. Date of filing: [illegible]  
21. Signature of registrar: [illegible]  
22. Date of filing: [illegible]

23. Name of registrar: [illegible]  
24. Address of registrar: [illegible]  
25. Date of filing: [illegible]  
26. Signature of registrar: [illegible]  
27. Date of filing: [illegible]

28. Name of registrar: [illegible]  
29. Address of registrar: [illegible]  
30. Date of filing: [illegible]  
31. Signature of registrar: [illegible]  
32. Date of filing: [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01224		01131	
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Willanda</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>70-3</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Maye Robert Earl</b>		4. DATE OF DEATH Month Day Year <b>1 9 19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-XX 41</b>
9. AGE (In years last birthday) <b>24</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dalthia Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Dalthia Edwards</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.  17. INFORMANT  Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of Brain</b> <b>8144</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Trauma</b> DUE TO (c) <b>Auto Accident</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>driver of car, struck from behind, hit bridge abutment</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>5:05 pm 12-24 1965</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>automobile</b>	
20f. (City or town) <b>Greenbelt</b>		20g. (County) <b>P.G.</b>	
20h. (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>1-10-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>1-11-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Flanagan &amp; Parker F.H.</b>		23d. LOCATION (City or Town) (County) (State) <b>Greenville, N. C.</b>	
24. FUNERAL DIRECTOR <b>ALEX POPE</b> <b>414 15th S.E. D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

11131

UNITED STATES DEPARTMENT OF HEALTH

FOR THE  
HEALTH OF

11131

UNITED STATES DEPARTMENT OF HEALTH

11131

UNITED STATES DEPARTMENT OF HEALTH

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*[Handwritten signature]*

11131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01225					01191						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)						
a. COUNTY <i>Prince Georges</i>					a. STATE <i>md</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>					b. COUNTY <i>Prince Georges</i>						
c. LENGTH OF STAY IN 1b <i>3 yrs</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4903 70TH AVE</i>					d. STREET ADDRESS <i>4903 70TH AVE</i>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
(Type or print)			First Middle Last			Month Day Year					
<i>FANNY WARE McCarthy</i>			<i>JAN 12 1966</i>			<i>FEMALE</i>			<i>WHITE</i>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			B. DATE OF BIRTH			9. AGE (In years last birthday) yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS.		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>13 JUNE 1897</i>			<i>68</i>			Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>WASHINGTON D.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>SAMUEL ENGELBRIGHT</i>			14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) <i>No.</i>			16. SOCIAL SECURITY NO. <i>578-16-4689</i>		
			17. INFORMANT <i>Edwin J. McCarthy</i>			Address <i>Same as #2</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>									<i>4 hrs</i>		
332X DUE TO (b) <i>GENERALIZED ARTERIOSCLEROSIS</i>									<i>4 yrs</i>		
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>JAN 1966</i> to <i>1/12</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>1/12</i> , 19 <i>66</i> , and that death occurred at <i>5 A</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Norman D. Comcal</i>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/12/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>NORMAN D. COMCAL</i>					22d. ADDRESS <i>3303 PENNY ST MT RAINIER MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE THEREOF <i>15 JAN 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FR. LINCOLN CEMETERY</i>			23d. LOCATION (City, town or county) (State) <i>BLADENSBURG, MARYLAND</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. Riverdale, Md.</i>					ADDRESS		25a. REC'D BY REGISTRAR <i>JAN 17 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

1911

1911

18 June 1897

WASHINGTON D.C.

UNKNOWN

ENGLERBRIGHT

2-MULT

John J. McGee

Blanchard

John J. McGee

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01227

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02718

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>	
c. LENGTH OF STAY IN 1b <b>4 days</b>		d. STREET ADDRESS <b>4203 54th Place</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pete Gillian McNeal</b>		4. DATE OF DEATH Month Day Year <b>Jan. 31 19 66</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 May 1907</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOOK KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BANKING</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES P. Mc NEAL</b>		14. MOTHER'S MAIDEN NAME <b>VIOLA BELFIELD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>224 18 3632 HA</b>	
17. INFORMANT <b>MRS. FLORENCE G. McNEAL</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burns - 30% of body surface</b> <b>9167</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AND Debility from cerebro-vascular occlusion</b> DUE TO (c) <b>1 month</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothing caught fire while smoking in chair</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>2:00 PM 27 Jan. 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing home</b>		20f. (City or town) (County) (State) <b>6119 43rd St. Riverdale PG Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>2-1-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, City, Town, or County) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4 FEB 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON, NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co Riverdale, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>31 days</b>		d. STREET ADDRESS <b>2025 Ravenswood Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospo.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy T. Meek</b>		4. DATE OF DEATH <b>Jan. 9 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 15, 1915</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR <b>90</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MASS.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>RICHARD E. BRAESE</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALICE WILSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Mrs DOROTHY Lundquist</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Coronary arteriosclerotic heart disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) this hospital attended the deceased from <b>Dec 7, 1965</b> to <b>Jan 9, 1966</b> , that (1) (we) last saw the deceased alive on <b>Jan 7, 1966</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William D. Rosson M.D.</b>		22b. DATE SIGNED <b>Jan. 10, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William D. Rosson, M.D.</b>		22d. ADDRESS <b>5701 85th Ave. Hyattsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>JAN 10, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY, WASH. D.C.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Harold S. Wade, Laurel, Md</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geo</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			c. LENGTH OF STAY IN 1b <u>12 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			16-15	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>So. Md. Hospital Center</u>					d. STREET ADDRESS <u>Box 79-McKendree Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Meier)</u>		First		Middle		Last		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1909</u>		9. AGE (In years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. Va</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Alfred Meier</u>		Address <u>Box 79</u> <u>Brandy</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive heart failure</u> <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral + Bronchopneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 29, 1966</u> , to <u>Jan. 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan. 29, 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 29, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>					22d. ADDRESS <u>Southern Md. Hosp., Clinton, Md.</u>				
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-3-1966</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>WASHINGTON NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>SUITLAND MARYLAND</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>					ADDRESS <u>Riversdale, Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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June 8, 1952

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Box 10

Mr. Alfred Miller, Washington, D.C.

U.S. 1/2

U.S. 1/2

ALFRED E. LARIN, M.D.

Box 10, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01229		01193									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C. Hillside</b> d. STREET ADDRESS <b>1121 59th Avenue, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Vincent</b> First <b>N. M. N.</b> Middle <b>Messineo</b> Last			4. DATE OF DEATH <b>January</b> Month <b>23</b> Day <b>1966</b> Year			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>6-1-03</b>			9. AGE (In years last birthday) <b>62</b> yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe repairman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Andrew Messineo</b>						14. MOTHER'S MAIDEN NAME <b>Anna Boniveri</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>2-24-66-11-11-11</b>			17. INFORMANT <b>Vincent P. Messineo</b> Address <b>5808 - M Hillside Park</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Emphysema</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 yr.</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 21</b> , 19 <b>66</b> , to <b>Jan. 23</b> , 19 <b>66</b> , that <del>we</del> last saw the deceased alive on <b>Jan. 23</b> , 19 <b>66</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>William D. Rosson</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>William D. Rosson, M.D.</b>						22b. DATE SIGNED <b>1/24/66</b>			22d. ADDRESS <b>5701 85th Ave. Hyattsville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1-27-66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Edgar Hill Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Swirland Md.</b>		
24. FUNERAL DIRECTOR <b>W. W. Chambers</b> ADDRESS <b>517-11 St. SE</b>						25a. REC'D BY REGISTRAR <b>DATE JAN 28 1966</b>			25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>		

01193

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Prince George's General Hospital  
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Washington, D.C.  
1131 20th Avenue, N.E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01230		01194	
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b> c. LENGTH OF STAY IN 1b <b>3 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>902 Nichold Srive</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b> d. STREET ADDRESS <b>902 Nichold Drive.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Doris Melbourne Miles</b> First Middle Last 4. DATE OF DEATH <b>January 28 19 66</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Caucasian</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>October 27, 1888</b> 9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Marion Station, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ROBERT MELBOURNE (deceased)</b> 14. MOTHER'S MAIDEN NAME <b>JENNIE GOTTMAN (deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>220-28-4695-D</b> 17. INFORMANT <b>Mr. Hall M. Miles, Jr., same as #2</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>331X</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 8</b> , 19 <b>61</b> , to <b>Jan 28</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Jan 28</b> 19 <b>66</b> , and that death occurred at <b>3P</b> M, from the causes and on the date stated above. 22a. SIGNATURE <b>Robert S. McCeney</b> 22c. PHYSICIAN'S NAME (Type) <b>Robert S. McCeney, M.D.</b> 22d. ADDRESS <b>402 Main St., Laurel, Maryland</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>Jan. 31, 1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery,</b> 23d. LOCATION (City, town or county) (State) <b>Marion Station, Maryland</b>		24. FUNERAL DIRECTOR <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b> 25a. REC'D BY REGISTRAR <b>FEB 4 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD</u> c. LENGTH OF STAY IN b <u>16 d</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR 4922 LA SALLE RD</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>XXXXXX</u> b. COUNTY <u>XXXXX</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>3426</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>BEULAH R. MILLER</u>		<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>9</u> Year <u>1966</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-4-1887</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>—</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cumberland Md</u>	
<b>13. FATHER'S NAME</b> <u>JOHN JACOB MILLER</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>FANNIE E. COULTER</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>LABOR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>OSTEOARTHRITIS, BOTH KNEES</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>3</u> p.m. <u>1966</u>	<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 22, 1965</u> <b>to</b> <u>Jan. 9, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Jan. 9, 1966</u> <b>and that death occurred at</b> <u>3:45 P.M.</u> <b>from the causes and on the date stated above.</b>		<b>22b. DATE SIGNED</b> <u>—</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>A. J. CONNOLLY, M.D.</u>		<b>22d. ADDRESS</b> <u>1635 Irving St. N.W. - Washington, D.C.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>	<b>23b. DATE THEREOF</b> <u>1/12/66</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oakdale Cemetery</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S. H. Hines Company</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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Removal 1/10/66  
The S. H. Hines Company  
2501 Fifth St., N.W.  
JAN 12 1966  
Original destroyed  
by Hines Co.  
JAN 12 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01232					01196				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Prince Georges					a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale					b. COUNTY Prince Georges				
c. LENGTH OF STAY IN 1b 16-1					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital					d. STREET ADDRESS 10-M Laurel Hill Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Pearl Irene Miller					Month Day Year January 17, 19 66				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-05		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (County & State, or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Beech Clyde					14. MOTHER'S MAIDEN NAME Job, Mary H.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Husband/Medical Record		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Congestive Heart Failure DUE TO (b) Uremia DUE TO (c) General arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesely and Diabetes Mellitus 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from June, 1962 to 18 JAN, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at 2:00 P.M., from the causes and on the date stated above.									
22a. SIGNATURE C. J. H. Malin					22b. DATE SIGNED 18 JAN 1966				
22c. PHYSICIAN'S NAME (Type) L. W. Malin, M. D.					22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/1966		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		23d. LOCATION (City, town or county) (State) Suitland Rd. Pr. Geo. Co.			
24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale Md					25a. REC'D BY REGISTRAR DATE JAN 24 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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DEPARTMENT OF HEALTH

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File permit and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01233

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01197

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN lb <b>15 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>6019 67th. Place</b>			
3. NAME OF DECEASED (Type or print) <b>Wilburn B. Milliken</b>				4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 April 1909</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b> Hours <b>66</b> Min.		11. BIRTHPLACE (State or foreign country) <b>TENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN, ICE CREAM.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GOOD HUMOR CO.</b>			
13. FATHER'S NAME <b>WILLIAM B. MILLIKEN</b>				14. MOTHER'S MAIDEN NAME <b>AMELIA ELMORE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>W.W. II</b>				16. SOCIAL SECURITY NO. <b>229 05 0789</b>		17. INFORMANT <b>Winifred G. MILLIKEN,</b> Address <b>318 BRYANT ST. N.E. WASHINGTON, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>From fracture dislocation of C5 vertebrae</b> DUE TO (c) <b>15 days</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down steps</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:30pm</b> 12-30-19 65				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <b>6410 63rd. Place, Riverdale, Md.</b>	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
21. ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>				22. DATE SIGNED <b>1-16-66</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>18 JAN 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co Riverdale, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	



70110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				d. STREET ADDRESS <u>Washington -- DC, 16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Point Branch Nursing Home Inc</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>L.</u> Last <u>Montague</u>						4. DATE OF DEATH <u>JAN - 15</u> 19 <u>66</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-11-84</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>-</u>	
13. FATHER'S NAME <u>Conrad Senkind</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Buttner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>David P. Montague</u> Address <u>(Son)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of penis</u> <u>157X</u> DUE TO (b) <u>Carcinoma of pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-20, 1965</u> to <u>1-15, 1966</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>R.D. Bancroft M.D.</u>						22b. DATE SIGNED <u>JAN 20 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>R.D. Bancroft, M.D.</u>		22d. ADDRESS <u>2513 Buck Lodge Rd. Adelphi, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairfax Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Fairfax, Va.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Valley's Funeral Home Inc.</u>						ADDRESS <u>Mt. Rainier Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	





08110

01830

10/10/10

10/10/10

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01236

## CERTIFICATE OF DEATH

01200

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DC M.D.</b> b. COUNTY <b>PR. GEORGE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LANHAM</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LANHAM</b> Washington <b>47-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4104 MAGNOLIA GARDEN NURSING HOME</b>				d. STREET ADDRESS <b>5911 7th Street, N.D.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis E. Montgomery</b>				4. DATE OF DEATH Month Day Year <b>Jan. 22 1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 21 1986</b>	
9. AGE in years last birthday <b>79</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN-RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CAPITOL TRANSIT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>FRANCIS MONTGOMERY</b>				14. MOTHER'S MAIDEN NAME <b>MARY LOUISE SWAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>HARRY MONTGOMERY - 5911-7th St. N.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADIPLOCLEOSIS GENERALIZED</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stroke - Cerebral thrombosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19 <b>20</b> to <b>Jan. 22 1966</b> that (I) (we) last saw the deceased alive on <b>Jan. 22 1966</b> , and that death occurred at <b>10 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>Jan. 22 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>	
22d. ADDRESS <b>[Signature]</b>				22e. MED. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/26/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL</b>		23d. LOCATION (City, town or county) (State) <b>WASH. D.C.</b>	
24. FUNERAL DIRECTOR <b>JAS. T. RYAN, INC.</b>		24b. ADDRESS <b>17 PA. AVE., S. E. DC 3</b>		25a. REC'D BY REGISTRAR <b>DATE 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



01100

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>						c. LENGTH OF STAY IN 1b <b>5 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>						d. STREET ADDRESS <b>College Park</b>					
3. NAME OF DECEASED (Type or print) <b>Bryon Martin Moore</b>						4. DATE OF DEATH <b>Jan. 26 1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1896</b>		9. AGE (in years last birthday) <b>69 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired policeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Police Department</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Abram Moore</b>						14. MOTHER'S MAIDEN NAME <b>Mary Southwell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>W W 1 577 24 3966</b>		17. INFORMANT <b>Margaret E Moore College Park, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Emboli</b> <b>4201</b> DUE TO <b>Embolization of rt. femoral artery (5 days post-operative status)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of right and left atrial appendages.</b> (c) <b>Coronary Arteriosclerotic Heart Disease.</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 21</b> , 1966, to <b>Jan. 26</b> , 1966, that (I) <del>was</del> last saw the deceased alive on <b>Jan. 26</b> , 1966, and that death occurred at <b>11:45 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William A. Holbrook</b>						22b. DATE SIGNED <b>27 Jan. 1966.</b>					
22c. PHYSICIAN'S NAME (Type) <b>William A. Holbrook, M.D.</b>						22d. ADDRESS <b>4500 College Ave. College Park, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan 31, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

101801

British Consulate

London

British Consulate

College Park

2 days

2 days

1001 Avenue Street

1001 Avenue Street

Jan. 20

London

British

British

WAVE

WAVE

British Consulate

British Consulate

British Consulate

British Consulate

London

British Consulate

British Consulate

Jan. 21

11.15 AM

11.15 AM

Jan. 22

British Consulate

British Consulate

British Consulate

British Consulate

British Consulate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01238						01202					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			a. STATE		
Prince George's			Cheverly			D.O.A.			Maryland Prince George		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. STREET ADDRESS			8. IS RESIDENCE ON A FARM?		
Prince George's General Hospital						3308 Buchanan			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
FRANCIS A.			MORAN			4. DATE OF DEATH			Month Day Year		
JANUARY 20 1966			5. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		
MALE			WHITE			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH		
AUGUST 6th 1894			9. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.		
71 yrs.			Months			Days			Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		
Retired						Washington Light			VIRGINIA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
PATRICK Moran						Johanna Scanlon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.			17. INFORMANT		
						5-77-07-9321			Edith Moran		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:						3 days					
IMMEDIATE CAUSE (a)						Myocardial infarction					
4201 DUE TO						Arterio Sclerosis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						3 and					
DUE TO											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?					
disturb						YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED					
Hour a.m. 19						While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Oct, 1966, to Jan 20, 1966 that (I) (we) last saw the deceased alive on Jan 19 1966, and that death occurred at 1:20 A.M. from the causes and on the date stated above.						22b. DATE SIGNED					
22a. SIGNATURE						1-20-66					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
Dr. Leo R. Levitsky						3408 Rhode Island Ave., Mt. Rainier, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF					
Burial						1-24-1966					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City, town or county) (State)					
Mt. Olivet						Wash. D.C.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR					
Robert A. Mattingly						131-11 JAN 24 1966					
25b. REGISTRAR'S SIGNATURE						J. Charles Judge					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01239						01203					
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6000 42 avenue.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville Md. d. STREET ADDRESS 6000 42 avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John F. Middle Neitzey Last 4. DATE OF DEATH Month Jan 12, Year 19 66											
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 7, 1895		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Gas Service station				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME John F. Neitzey						14. MOTHER'S MAIDEN NAME Virginia Dutton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I				16. SOCIAL SECURITY NO. 217 32 1455		17. INFORMANT Lillian Gertrude Neitzey Address Hyattsville Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses 332X DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced Pulmonary Emphysema Pulmonary Heart Disease										INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1 - 12 - 1966, to Jan 12, 1966, that (I) (we) last saw the deceased alive on 1 - 12 - 1966, and that death occurred at 2 PM, from the causes and on the date stated above.											
22a. SIGNATURE Richard L. Whelton M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan 13, 1966			
22c. PHYSICIAN'S NAME (Type) RICHARD L. WHELTON						22d. ADDRESS Silver Springs, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan 14, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR JAN 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

01830

01830

COLLECTION

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01240		01204	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	c. LENGTH OF STAY IN 1b <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>5412 56th. Avenue, Apt. 102</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Bertha Olivia Nelson</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2 Oct. 1919</b>
9. AGE (In years lost birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAB. MACHINE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>ARTHUR FERGUSON</b>	
14. MOTHER'S MAIDEN NAME <b>BERTHA SMITH</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>BEVERLY J. LAKEY</b> Address <b>7804 NORTHERY AV GLENN DALE, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO (b) <b>Coronary artery occlusion</b> DUE TO <b>From arteriosclerotic heart disease</b> (c) <b>lost.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-11-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>13 JAN 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG MARYLAND</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co Riverdale, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01241

01205

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's County</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Maryland</u> c. LENGTH OF STAY IN 1b <u>4 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Manor - 4922 LaSalle Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> d. STREET ADDRESS <u>1346 Connecticut Ave., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>2</u> Year <u>1966</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 31, 1886</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Roman Catholic Priest</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Professor - C.U.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ireland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>									
<b>13. FATHER'S NAME</b> <u>Francis O'Grady</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Hayes</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>578-52-5890</u> <b>17. INFORMANT</b> <u>Sister Magdalene Marie - Carroll Manor</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>4500</u> (b) <u>  </u> DUE TO <u>Arteriosclerosis</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>20 yrs.</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> 19 <u>  </u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u> <u>  </u> <u>  </u>													
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>June 1940</u> to <u>12/1/66</u> , that (I) (we) last saw the deceased alive on <u>12/31 1965</u> , and that death occurred <u>10:46</u> M, from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>E. H. Aschenbach</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>E. H. Aschenbach</u> <b>22d. ADDRESS</b> <u>1841 Colled NW</u> <b>22b. DATE SIGNED</b> <u>  </u>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Jan. 5, 1966</u>		<b>23c. NAME OF CEMETERY</b> <u>Mount Olivet</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D. C.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis J. Collins</u> <b>ADDRESS</b> <u>321-14th St NW Wash. DC</u>								<b>25a. REC'D BY REGISTRAR</b> <u>JAN 6 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01502

01502

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurring and low contrast.

Vertical text on the right margin, possibly a date or reference number, including the word "FEBRUARY".

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01242

## CERTIFICATE OF DEATH

01206

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> NOT APPLICABLE. COUNTY <b>PRINCE GEO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7805 PENNA. AVE SE</b> d. STREET ADDRESS <b>SUITLAND MD</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN lb <b>4 HRS.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>							
<b>3. NAME OF DECEASED</b> (Type or print)		First <b>NEWBORN</b> Middle <b>MALE</b> Last <b>PAGOS</b>		<b>4. DATE OF DEATH</b> Month <b>JANUARY</b> Day <b>29</b> Year <b>1966</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>CAUC</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>29 JANUARY 1966</b>	<b>9. AGE</b> (In years last birthday) <b>N/A</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>3</b> Days <b>19</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>N/A</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>N/A</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PG COUNTY, MARYLAND</b>			
<b>13. FATHER'S NAME</b> <b>CHRISTOPHER G. PAGOS</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>GERALDINE E. DUMESNELL</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>N/A</b>				<b>17. INFORMANT</b> Address <b>SUITLAND, MD.</b> <b>CHRISTOPHER G. PAGOS 7805 PENNA. AVE S.E.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>ANOXIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>BILATERAL PNEUMOTHORACES</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from 29 JANUARY, 1966, to 29 JANUARY, 1966, that (I) (X) last saw the deceased alive on 29 JANUARY, 1966, and that death occurred at 3:55 A.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Harris C. Faigel</i>		<b>22b. DATE</b> <b>29 JAN 1966</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>HARRIS C. FAIGEL CAPT USAF MC</b>			
<b>22d. ADDRESS</b> <b>USAF HOSPITAL ANDREWS</b>		<b>22e. REC'D BY REGISTRAR</b> <b>22f. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>2-1-66</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Virginia</b>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>4308 Suitland Rd Suitland, Md</b>							

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01243

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01207

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Air Force Base Hosp.</u>		d. STREET ADDRESS <u>3776-5 Luzianne Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter B Parks</u>		4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 June 1905</u> 60 yrs.
9. AGE (In years lost birthday) <u>60</u>		10. IF UNDER 1 YEAR: Months <u>24</u> Days <u>19</u> Hours <u>66</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
12. BIRTHPLACE (State or foreign country) <u>Texas</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Unknown</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>Unknown</u>	
18. INFORMANT <u>Howard D. Hubbard</u>		Address <u>Same as #2</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>Unknown</u> (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver - Known 5 months</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-25-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-30-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Union Oklahoma</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers 6 Ave. 517-11th St. S.E.</u>		25. REC'D BY REGISTRAR <u>FEB 1 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11503



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. One along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01244

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01208

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>		e. STREET ADDRESS <u>5013 Naples Ave.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Lee</u> Last <u>Perrigon</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-65</u>
9. AGE (In years lost birthday) yrs. <u>9</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles F. Perrigon</u>		14. MOTHER'S MAIDEN NAME <u>Roxie Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Charles F. Perrigon</u>		Address <u>Same as #2 (father)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Patent ductus arteriosus and patent foramen ovale</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Congenital</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale</u>		22. DATE SIGNED <u>1-2-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1966</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

5-160880

432

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01209

FOR STATE HEALTH DEPT

01245

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's</b>				d. STREET ADDRESS <b>6516 Rosemont Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Juan</b> Middle <b>NMI Planas</b> Last <b>XXXXX</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1924</b>		9. AGE (In years last birthday) <b>41</b> yrs.	10. IF UNDER 1 YEAR Months <b>41</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Elevator Service St. Elizabeth</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hosp</b>		11. BIRTHPLACE (State or foreign country) <b>Puerto Rico</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Juan Planas</b>				14. MOTHER'S MAIDEN NAME <b>Mercedes Pastranas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lucy M. Planas</b> Address <b>Same as # 2.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>				22. DATE SIGNED <b>2-1-66</b> Rivendale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 5th 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Municipal Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Trujillo Alto, Puerto Rico.</b>	
24. FUNERAL DIRECTOR <b>Simmons Brothers 1661- Good Hope Road, SE DC</b> Address <b>Washington</b>				25a. REC'D BY REGISTRAR <b>Feb 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11350

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12 1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01246

## CERTIFICATE OF DEATH

01210

<b>1. PLACE OF DEATH</b> a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6414 Pinewood Drive		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS 6414 Pinewood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) BATSON SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Richton, Mississippi 12. CITIZEN OF WHAT COUNTRY? U.S.A.		<b>4. DATE OF DEATH</b> January 22 1966 8. DATE OF BIRTH August 13, 1917 9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>13. FATHER'S NAME</b> William Thomas Pope <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> Address Virginia M. Pope 6414 Pinewood Drive		<b>14. MOTHER'S MAIDEN NAME</b> Katherine M. Walley	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 Cardiovascular collapse DUE TO (b) Dehydration & Kalaemia DUE TO (c) Carcinomatosis & Intestinal obstruction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from 1-5-1965 to 1-22-1966, that (I) (we) last saw the deceased alive on 1-22-1966, and that death occurred at 11:30 A.M., from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <i>Charles J. Judge</i> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) MARK PILKOR <b>22d. ADDRESS</b> 7200 MARLBORO PIKE DIST. NGTS. MD	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial <b>23b. DATE THEREOF</b> 1-25-66 <b>23c. NAME OF CEMETERY OR CREMATORY</b> Trinity Memorial Park <b>23d. LOCATION</b> (City, town or county) Waldorf (State) Maryland		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Wilhelm Funeral Home 4308 Suitland Rd Suitland <b>25a. REC'D BY REGISTRAR</b> JAN 26 1966 <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

01510

252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01247 <i>Items #11, 12, 13, &amp; 14 taken from birth cert.</i> <span style="float: right;">01211</span>									
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY				
Prince Georges MARYLAND					Maryland Prince Georges				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Cheverly			34 hrs		Oakcrest 16-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
Prince Georges General Hospital					304 Holly Street				
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH			Month Day Year	
Baby Girl			Powell		Jan.			24 19 66	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		22 Jan., 1966		yrs. - Months - Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						Cheverly, Pr. Geo.		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Alrick Armstead Powell					Pearl Jeanette Wallace				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory distress (atelectasis)</i> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Premature Birth</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>the</del> (this hospital) attended the deceased from Jan. 22, 1966, to Jan. 24, 1966, that <del>it</del> (we) last saw the deceased alive on Jan. 24, 1966, and that death occurred at 12:10 AM on the causes and on the date stated above.									
22a. SIGNATURE <i>Leroy E. Hoeck</i>					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type)	
					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			Jan. 26, 1966	
Leroy E. Hoeck, M.D.					22d. ADDRESS				
					3611 Branch Ave. S.E. Washington, D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
126-66			1-26-66		Sneth Town, Md.		Luzon, Md		
24. FUNERAL DIRECTOR <i>Wm. J. Gacy</i> 1722-7th St. N.W. Wash. D.C.					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					DATE		<i>John Gacy</i>		
					FEB 1 1966				

6-153865



01311

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01248

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01212

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>109 S. Fayette Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Daniel Powell</b>			4. DATE OF DEATH Month Day Year <b>1 9 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>29 Aug. 1918</b>	9. AGE (In years lost birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>19 66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Willie L. Powell</b>		
14. MOTHER'S MAIDEN NAME <b>Pauline Cook</b>			15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>223-32-1880</b>			17. INFORMANT Address <b>Mrs. Harvey E. Bailey Hyattsville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>From laceration of brain</b> DUE TO <b>and fractures of left humerus, left pelvis,</b> (c) <b>and left rib cage.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by 2 cars.</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>6:49 p.m. 1-9- 19 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 495 - St. Barnabas Road, Prince Geo. Co.</b>	
20f. (City or town) (County) (State) <b>Prince George's Co. Prince George's Co. Maryland</b>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		M.O. <b>John Kehoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>1-10-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		24. FUNERAL DIRECTOR <b>Cunningham Funeral Home, Inc.</b> <b>2400 Mount Airy</b>			
25a. REC'D BY REGISTRAR DATE <b>JAN 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01249

01213

<p>1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>SOUTH CARLONIA</b> b. COUNTY <b>SUMTER</b></p>			
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b></p>				<p>c. LENGTH OF STAY IN 1b <b>21 DAYS</b></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b></p>				<p>d. STREET ADDRESS <b>213 Pinckney St</b></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <b>OLIVIA JACQUELINE PRESCOTT</b></p>				<p>4. DATE OF DEATH Month Day Year <b>JANUARY 25 1966</b></p>			
<p>5. SEX <b>FEMALE</b></p>		<p>6. COLOR OR RACE <b>CAU</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>6 Nov 1924</b></p>	
<p>9. AGE (In years last birthday) <b>41</b> yrs.</p>		<p>IF UNDER 1 YEAR Months Days</p>		<p>IF UNDER 24 HRS. Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Unknown, Florida</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b></p>							
<p>13. FATHER'S NAME <b>unknown</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no N/A</b></p>				<p>16. SOCIAL SECURITY NO. <b>unk</b></p>		<p>17. INFORMANT Address <b>Husband Same as # 2</b></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>UREMIA</b> DUE TO (c) <b>CANCER OF CERVIX - METASTASES</b></p>							<p>INTERVAL BETWEEN ONSET AND DEATH <b>Second</b> <b>1 week</b> <b>3 years</b></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>—</b></p>							<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b></p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m. —</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b></p>		<p>20f. (City or town) (County) (State) <b>—</b></p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <b>JAN 4</b>, 19<b>66</b>, to <b>JAN 25</b>, 19<b>66</b>, that (I) (we) last saw the deceased alive on <b>24 JAN</b>, 19<b>66</b>, and that death occurred at <b>0303M</b>, from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <i>Charles D. Phelps, MD</i></p>				<p>22b. DATE SIGNED <b>25 JAN 1966</b></p>		<p>22c. PHYSICIAN'S NAME (Type) <b>CHARLES D. PHELPS, CAPT, USAF</b></p>	
<p>22d. ADDRESS <b>USAF Hosp, Andrews, Andrews AFB Wash, DC</b></p>				<p>22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>		<p>22f. ATTENDING PHYS. <input checked="" type="checkbox"/></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>23b. DATE THEREOF <b>1/29/66</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>FLORENCE NAT CEMETERY FLORENCE SCAROLINA SC</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>—</b></p>	
<p>24. FUNERAL DIRECTOR <b>W W Chamberlain 517 11th ST SE DC</b></p>				<p>25a. REC'D BY REGISTRAR <b>FEB 1 1966</b></p>		<p>25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i></p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

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<div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div>												
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5602 Rhode Island Ave.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville 16-1 d. STREET ADDRESS 5602 Rhode Island Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE JEROME QUEEN			4. DATE OF DEATH Month Day Year 1 28 1966			5. SEX male			6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 1-26-05			9. AGE (In years last birthday) 61 yrs.			10. UNDER 1 YEAR Months Days Hours Min.			11. UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor						10b. KIND OF BUSINESS OR INDUSTRY School			11. BIRTHPLACE (County & State, or foreign country) Pr. Georges Co., Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.						13. FATHER'S NAME George Washington Queen						
14. MOTHER'S MAIDEN NAME Carrie Johnson						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						
16. SOCIAL SECURITY NO.						17. INFORMANT Address sister - Carrie E. Brown						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary lung cancer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-17, 1966, to 1-28, 1966, that (I) (we) last saw the deceased alive on 1-17, 1966, and that death occurred at 8:30 PM, from the causes and on the date stated above.												
22a. SIGNATURE D. R. Purdie 22c. PHYSICIAN'S NAME (Type) D. R. Purdie, M. D.						22b. DATE SIGNED 1-31-66 22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.						
23a. BURIAL / CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 2-4-66			23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery			23d. LOCATION (City, town or county) (State) Bladensburg Rd. NE, D.C.			
24. FUNERAL DIRECTOR A. S. Washington & Sons 4925 Deane Ave						25a. REC'D BY REGISTRAR FEB 3 1966			25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01251					01215						
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 3727 Donnell Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Rackey			4. DATE OF DEATH Month Day Year January 14 19 66		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. 2						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 12, 1966		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- None --				10b. KIND OF BUSINESS OR INDUSTRY None --		13. FATHER'S NAME Robert A. Rackey				14. MOTHER'S MAIDEN NAME Eleanor J. Mc Donald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Robert A. Rackey Same as #2				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (he) (this hospital) attended the deceased from Jan. 12, 1966, to Jan. 14, 1966, that (he) (we) last saw the deceased alive on Jan. 14, 1966, and that death occurred at 2:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE Carolina Paredes Manlapax, M.D.						22b. DATE SIGNED am 1-14-66		22c. PHYSICIAN'S NAME (Type) Carolina Paredes Manlapax, M.D.		22d. ADDRESS Prince George's Genl. Hosp. Cheverly Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 1-15-66		23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Em.			23d. LOCATION (City, town or county) (State) Plover Hill, Md.			
24. FUNERAL DIRECTOR W. W. Chambers G. Inc. 517-11th St. S.E.						25a. REC'D BY REGISTRAR JAN 20 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Pr. Geo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Geo. Gen. Hosp.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>				d. STREET ADDRESS <b>3801 - Kenilworth Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Upton</b>		First <b>D.</b>		Middle <b>Reid</b>		Last <b>Jan.</b>		4. DATE OF DEATH Month <b>12</b> Day <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/6/1910</b>		9. AGE (In years last birthday) yrs. <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Boyd, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John H. Reid</b>				14. MOTHER'S MAIDEN NAME <b>Rohoda Stewart</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT <b>Mrs. Dixie G. Reid (above address)</b>		Address <b>(Wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO <b>From arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>And multiple myeloma</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>over 1 yr.</b> <b>over 2 Mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>Feb. 1962</b> , to <b>Jan. 12, 1966</b> that (I) <b>(yes)</b> last saw the deceased alive on <b>Jan. 7, 1966</b> , and that death occurred at <b>10:30 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John Kehoe</b>				M.D. <b>John Kehoe, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan 13-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John Kehoe, M.D.</b>				22d. ADDRESS <b>Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arl. Natl. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01253					01217					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY		PRINCE George			a. STATE		Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Hyattsville			b. COUNTY		Prince George's			
c. LENGTH OF STAY IN 1b		4 years			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
3221- Toledo Place					3221- Toledo Place					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
Bessie					Month Day Year					
First Middle Last					Jan 5 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Female		White		NEVER MARRIED		February 24 1888		77 yrs.		
				WIDOWED				IF UNDER 1 YEAR IF UNDER 24 HRS.		
				DIVORCED				Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					
Housewife					Domestic					
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?					
Washington, D.C.					U.S.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
William Hill					Emma Chrisman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					
no										
17. INFORMANT					Address					
Merce					Mrs Margaret E. Biker					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a)										
491X Bronchopneumonia.										
DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO										
(b)										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
Arthritis of legs										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
None										
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.			While at work Not While at work		None					
21. I certify that (I) (this hospital) attended the deceased from January 1, 1958, to January 5, 1966, that (I) (we) last saw the deceased alive on January 5, 1966, and that death occurred at 7:30 P.M. from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED					
James M. Hoffus					January 5, 1966					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
JAMES M. HOFFUS M.D.					5415 Connecticut Ave N.W. Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial			Jan. 8 - 1966		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Simmons Bros.					JAN 10 1966		J. Charles Judge			

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CERTIFICATE OF DEATH

NAME

*[Signature]*



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01254

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01218

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1406 Langley Way Apt. 20		d. STREET ADDRESS 1406 Langley Way, Apt. 20	
3. NAME OF DECEASED (Type or print) First Middle Last Egbert Lee Roark		4. DATE OF DEATH Month Day Year 1 18 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-1913
9. AGE (In years lost birthday) yrs. 52		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) NORTH CAROLINA		13. CITIZEN OF WHAT COUNTRY? U.S.	
14. FATHER'S NAME LEE ROARK		15. MOTHER'S MAIDEN NAME ANNIE WILSON	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II		17. SOCIAL SECURITY NO. UNKNOWN	
18. INFORMANT RUTH T. ROARK		19. ADDRESS 180 TALBOT ST. APT E. 2. ROCKVILLE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Heart failure DUE TO (b) From occlusion of coronary artery. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH min. unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 1-19-66	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		23. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN 21, 1966	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON, NATIONAL
23d. LOCATION (City or Town) ARLINGTON, VIRGINIA		(County) (State)	
24. FUNERAL DIRECTOR W. W. Chambers Co Riverdale, Md.		25a. REC'D BY REGISTRAR DATE JAN 24 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01219

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XXXXXXX X Prince Geor. General Hosp.</u>		d. STREET ADDRESS <u>7502 Small Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>LAST</u> <u>Settle</u> <u>Margaret</u>		4. DATE OF DEATH <u>Jan. 19</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1919</u> 46 yrs.
9. AGE (In years) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Eckhart, Maryland,</u>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Jacob Seibert</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Groter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neurogenic Shock</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive Subarachnoid Hemorrhage</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (U) (this hospital) attended the deceased from <u>Jan 18</u> , 19 <u>66</u> , to <u>Jan 19</u> , 19 <u>66</u> , that (U) (we) last saw the deceased alive on <u>January 19, 1966</u> and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William D. Rosson M.D.</u>		22b. DATE SIGNED <u>1/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. Rosson, M.D.</u>		22d. ADDRESS <u>5701 85th Ave Hyattsville, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>1/20/66</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland.</u>
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. L. Judge</u>	

1390



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01256					01220				
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			d. STREET ADDRESS <b>3927 Madison Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Ralph M Shenberger</b>		First Middle Last		4. DATE OF DEATH <b>January 25 19 66</b>		Month Day Year		5. AGE (In years last birthday) <b>70</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-17-95</b>		9. AGE (In years last birthday) <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Pressman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Shenberger</b>					14. MOTHER'S MAIDEN NAME <b>Bertha Fink</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>W W 11</b>		17. INFORMANT <b>Edna Shenberger Hyattsville, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral marked pulmonary</b> <b>465 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>edema; Bilateral pulmonary</b> DUE TO (c) <b>emboli and marked emphysema</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19____, to <b>Present</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/25/66</b> 19____, and that death occurred at <b>12:15</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Gordon W. Kelley</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>25 Jan. 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Gordon Kelley, M.D.</b>					22d. ADDRESS <b>6124 41st Ave. Hyattsville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan 28, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>					25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

01280

OFFICE OF DEATH

01280

Prince George's

Naval

Wentworth

1 day

1017 Madison Street

Prince George's General Hospital

January 25

Shedden

M

Ralph

X

1-17-5

White

Male

1017 Madison Street

Shedden

12:15

23 Jan. 1950

1017 Madison Ave. Wentworth, Md.

Prince George's, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01257									
01221									
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 month &amp; 11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3358 Chillum Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Mary R Shepherd</b>			4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-9-88</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk- U.S. Govt.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Mastin</b>					14. MOTHER'S MAIDEN NAME <b>Mary ?</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. John L. Shepherd (above address)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli, Multiple (Son)</b> <b>157X</b> DUE TO (b) <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Carcinoma, Tail of the Pancreas.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 17</b> , 19 <b>65</b> , to <b>January 28</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>January 28</b> 19 <b>66</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Carolina Paredes Manlapaz, MD</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-1-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Carolina Paredes Manlapaz, MD</b>					22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>		
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>					ADDRESS <b>Mt. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

01258

01222

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 mo. 11 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ina C. Shifflette</b>		4. DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 April 1892</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Broy</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Shows</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary Gessford</b>		Address <b>Shadyside Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO <b>From Carcinoma of breast</b> (b) <b>And Arteriosclerotic heart disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>over 4 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of left hip Over 2 months</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Fell at home</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Bedroom of home</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>9:15am 10-29- 1965</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Same as #2</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-12-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 14, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25. REC'D BY REGISTRAR <b>JAN 17 1966</b>	
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

1933

1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>1 mo., 29 dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47-3</b> d. STREET ADDRESS <b>1728 Lamont St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Isaac</b>			First		Middle		Last		4. DATE OF DEATH Month <b>Jan.</b> Day <b>23</b> Year <b>19 66</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/15/1903</b>		9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Street Vendor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Iraq</b>			12. CITIZEN OF WHAT COUNTRY? <b>? IRAQ</b>		
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>D. C. General Hospital</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident, type undetermined, 331X</b> DUE TO <b>probably hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) <b>Cerebral arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Status postoperative craniotomies for cerebral arteriovenous fistula, 1946 and 1956</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> <b>1965</b> , to <b>1/23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/23/</b> 19 <b>66</b> , and that death occurred at <b>4:25 P.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Moe Weiss</b>						22b. DATE SIGNED <b>1/23/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHESED SHELEMMES CEM</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON D.C</b>			
24. FUNERAL DIRECTOR <b>Glenn Dale Funeral Home</b>						25a. REC'D BY REGISTRAR <b>JAN 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

01583

U. C.

Prince George

Washington

1 mo., 20 day

Green wife (young)

1725 Summit St. N. W.

Green wife (young)

Bliss

1925

2/15/1903

Male

Land

Green Vendor

Unknown

Unknown

U. C. General N. W. 12

no

U. C. General N. W. 12

1/23

1/23

Green wife (young)

Green wife (young)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01260

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01224

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Hospital</u>				d. STREET ADDRESS <u>5250 Oakcrest Dr. Apt. 306</u>			
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>E.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 5, 1908</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CASPER BROWNE</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE STEWART</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 058075</u>		17. INFORMANT <u>RALPH H. SMITH.</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aneurysm of circle of Willis</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>  </u> (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <u>  </u> of work <u>  </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>		EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>1-21-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/24/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland Maryland</u>	
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>				25a. REC'D BY REGISTRAR <u>JAN 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>	

11551

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

01261

01225

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Manuel Smith</b>		4. DATE OF DEATH <b>1 19 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 April 1913</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
13. FATHER'S NAME <b>Tilroe Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lula Buckham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Doris Smith (wife)</b>		Address <b>Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>From hypertensive arteriosclerotic heart disease over 1 yr.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-19-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Carver Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Laurel, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Suowden</b>		ADDRESS <b>Rockville, Md.</b>	
25a. REC'D BY REGISTRAR <b>JAN 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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18810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince Georges</b></span>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. LENGTH OF STAY IN 1b <b>6 days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>					e. STREET ADDRESS <b>5100 Emerson St.</b>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>First Middle Last</b> <b>Mary J Smith</b>					<b>4. DATE OF DEATH</b> Month <b>Jan</b> Day <b>11</b> Year <b>19 66</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4 Jan 1878</b>		<b>9. AGE</b> (In years last birthday) <b>87</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>James Franklin</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Ruth C. Green</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mrs. Elizabeth Goode (Daughter)</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500 Congestive Heart Failure sec. to</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> (c) <b>Anemia probably nutritional</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <del>the</del> (this hospital) attended the deceased from <b>Jan. 5</b> , 19 <b>66</b> , to <b>Jan. 11</b> , 19 <b>66</b> , that <del>we</del> last saw the deceased alive on <b>Jan. 11</b> , 19 <b>66</b> , and that death occurred at <b>5:35 AM</b> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>Carolina Paredes Manlapaz, M.D.</b>						<b>22b. DATE SIGNED</b> <b>1-11-66</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Carolina Paredes Manlapaz, M.D.</b>						<b>22d. ADDRESS</b> <b>Prince George's Genl. Hosp. Cheverly, Md</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>1/13/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Union</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Leesburg Va.</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Francis Gasch Sons</b>				<b>ADDRESS</b> <b>Hyattsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Jan 17 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>	

11386

James Franklin

James Franklin

James Franklin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>6 hr. 25 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>District Heights</b> d. STREET ADDRESS <b>2522 Addison Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Ronald) Baby</b> 4. DATE OF DEATH <b>Last Snow, Jr. January 20 1966</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 19, 1966</b> 9. AGE (in years last birthday) <b>6 yrs.</b> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>---</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ronald Eugene Snow, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elaine Ross</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b> 17. INFORMANT <b>M. Pauline Miller-Pike, 10515 Marlboro Upper Marlboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio vascular collapse</b> <b>7710</b> DUE TO <b>Inta uterine Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>---</b> DUE TO <b>Possibly Aplastic Bone marrow?</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs 25 min</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 19, 1966</b> to <b>Jan 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 20 1966</b> , and that death occurred at <b>2:25 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Mark H. Pillor</b> 22c. PHYSICIAN'S NAME (Type) <b>Ma rk H. Pillor, M. D.</b>		22b. DATE SIGNED <b>1/20/66</b> 22d. ADDRESS <b>7105 Wilburn Drive District Heights, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Bladensburg, Md.</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

• **1998** •

(continued)

(Р. Г. Ито) В.

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Donald Eugene Brown, Jr.

10-10-68

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15/05/99

Mr. J. H. Wilson, Jr.,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01264											
01227											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vista</u>				c. LENGTH OF STAY IN 1b <u>9 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mitchellville 16-1</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lottsford-Vista Road</u>						d. STREET ADDRESS <u>Lottsford-Vista Road</u>					
3. NAME OF DECEASED (Type or print) <u>Iida Mary Snowden</u>						4. DATE OF DEATH <u>Jan. 13 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 22 1889</u>		9. AGE (In years last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Thomas Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wood</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Dorothy F. Thomas Mitchellville</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO (b) <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>Hypertension, Essential</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12/13/65</u> to <u>1/13/66</u> , that (I) (we) last saw the deceased alive on <u>1/12/66</u> , and that death occurred <u>1/13/66</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry A. Vaise Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Vaise Jr.</u>						22d. ADDRESS <u>13008 95th Bowie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carrolls Chapel Ceme.</u>		23d. LOCATION (City, town or county) (State) <u>Mitchellville, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Funeral Home</u>						25a. REC'D BY REGISTRAR <u>Jan 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

01581

01581

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Vista Road" and "1987" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Edema</b> DUE TO <b>Myocardial Infarction and Fibrosis</b> (c) <b>Hypertensive Coronary Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-31</b> , 19 <b>65</b> to <b>1-16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-16-66</b> , 19 <b>66</b> , and that death occurred at <b>7:37 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>ZENAIIDA C. PALAD</b>		22b. DATE SIGNED <b>1/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ZENAIIDA C. PALAD</b>		22d. ADDRESS <b>PRINCE GEORGES GEN. HOSP</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-21-66</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Dale Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Glen Dale Md</b>	
24. FUNERAL DIRECTOR <b>As Washington + Sons</b>		25. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	
25a. REC'D BY REGISTRAR <b>IAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
012265			
01228			
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Brooklyn Road</b>	
3. NAME OF DECEASED (Type or print) <b>Noble</b>		4. DATE OF DEATH <b>Jan. 16 1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Color</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 10, 1877</b>	
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ARTHUR SNOWDEN</b>		14. MOTHER'S MAIDEN NAME <b>MARIA WILLIAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-076589</b>	
17. INFORMANT <b>MRS BLANCHE WARNER</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Edema</b> DUE TO <b>Myocardial Infarction and Fibrosis</b> (c) <b>Hypertensive Coronary Arteriosclerotic Heart Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

4954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>PRINCE GEORGE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>		e. STREET ADDRESS <b>5706 Geo Wash Drive</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS WILLIAM SOMERVILLE</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 18 1966</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 NOV 1893</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			
10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK CITY, N.Y.</b>			12. CITIZEN OF WHAT COUNTRY? <b>US</b>				
13. FATHER'S NAME <b>WILLIAM (NMN) SOMERVILLE</b>			14. MOTHER'S MAIDEN NAME <b>MARY (NMN) HANNIGAN</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1918</b>				
16. SOCIAL SECURITY NO. <b>060-07-2185</b>			17. INFORMANT Address <b>Col G.A. JOHNSON, SIL, Same as # 2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIAL NEPHROSCLEROSIS SEVERE</b> DUE TO (c) <b>HYPERTENSIVE ARTERIOSCLEROTIC C-V DISEASE</b>									INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b> <b>YEARS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>15 Jan</b> , 19 <b>66</b> , to <b>18 Jan</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>18 JAN</b> 19 <b>66</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Ramon Roig MD</b>			22b. DATE SIGNED <b>18 Jan 66</b>			22c. PHYSICIAN'S NAME (Type) <b>RAMON F ROIG, CAPT., USAF</b>				
22d. ADDRESS <b>USAF HOSP ANDREWS AIR FORCE BASE, MD</b>			22e. M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-21-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD</b>		23d. LOCATION (City, town or county) (State) <b>MANASSAS, N.Y.</b>				
24. FUNERAL DIRECTOR <b>W.W. Chambers 517 H ST SE.</b>		25a. REC'D BY REGISTRAR <b>JAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>						

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OFFICE OF THE

UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 01267 CERTIFICATE OF DEATH 01230

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>				d. STREET ADDRESS <u>505- Greenlawn Dr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>505- Greenlawn Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Josephine</u>			First <u>Ann</u> Middle <u>Sparkenbaugh</u> Last <u>Sparkenbaugh</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1965</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20, 1912</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>St. Paul, Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Harry Ashton</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE Remark</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Charles E. Sparkenbaugh same as #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of Liver</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>1 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August, 1965</u> , to <u>Jan 10, 1966</u> that (I) (we) last saw the deceased alive on <u>Jan 10 1966</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Morton A. Itschner</u>					22b. DATE SIGNED <u>1-11-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Morton A. Itschner</u>					22d. ADDRESS <u>9205-New Hampshire Ave. S.E.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>1/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Robinson Run Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sturgeon, Pa.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
ADDRESS <u>2901 14th St. N.W.</u>				DATE <u>JAN 13 1966</u>			

MEDICAL CERTIFICATION

and

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01268

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01231

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> <b>18 - 2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>Box # 148</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jarrett Speith</b>				4. DATE OF DEATH Month <b>1</b> Day <b>6</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 Aug. 1905</b>		9. AGE (In years lost birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES SPEITH</b>				14. MOTHER'S MAIDEN NAME <b>KATE LEISH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS CATHERINE ANN SPEITH LEONARDTOWN, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO (b) <b>From arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>1-7-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 10, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>LEONARDTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>JAN 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01269

## CERTIFICATE OF DEATH

01232

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE D. C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Nursing Home			d. STREET ADDRESS 2906 Erie St., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AUGUSTA Middle MARIA Last STANGE			4. DATE OF DEATH Month January Day 27, Year 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1874	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Sweden	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME August Johanson		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Son-Carl E. Stange		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease (c) Senility.			INTERVAL BETWEEN ONSET AND DEATH one week		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral Pyelonephritis - cerebral v. sufficing					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		
22a. SIGNATURE B. Bahrami			22b. DATE SIGNED 4/27/66		
22c. PHYSICIAN'S NAME (Type) Bahrami Bahrami			22d. ADDRESS 3003 Naylor Rd. S. E.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Jan. 30, 1966		23c. NAME OF CEMETERY OR CREMATORY Lees Crematory	
23d. LOCATION (City, town or county) (State) Washington DC		24. FUNERAL DIRECTOR J. Wm. Lees Sons		25a. REC'D BY REGISTRAR FEB 1 1966	
25b. REGISTRAR'S SIGNATURE		25c. ADDRESS 300 4th St., NE Wash. 2, DC			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01270

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01233

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>3716 Perry Street</b>	
3. NAME OF DECEASED (Type or print) <b>Florence E Stidman</b>		4. DATE OF DEATH <b>1 14 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-78</b>
9. AGE (In years lost birthday) <b>87</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Watts</b>		14. MOTHER'S MAIDEN NAME <b>Elena Dorrida</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-16-7848 D</b>	
17. INFORMANT <b>Miss Frances G. Stidman (above address)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>9040</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>And Sub-dural Hematoma, Right</b> DUE TO (c) <b>39 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Fell at home</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>9:00am. 12-5- 19 65</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Same as #2</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-14-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>	25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only one within 72 hours after death.

10528

10528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
012771						01234					
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hosp.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>Rt. 2 Box 269</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Louise</b>			First <b>Stokes</b>			Last			4. DATE OF DEATH Month <b>Jan</b> Day <b>9</b> Year <b>19 66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12, 1909</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursemaid</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Fam.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>N.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Willie Tharrington</b>						14. MOTHER'S MAIDEN NAME <b>Carrie Blacknell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>Miles Tharrington-Bro.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6001</b> DUE TO <b>1. Bronchopneumonia Lt. upper &amp; lower lobes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2. Bilateral marked pulmonary edema</b> DUE TO <b>3. Multiple abscesses Lt. Kidney, Bil. Hydronephrosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 5, 1965</b> to <b>Jan. 9, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 9, 1966</b> , and that death occurred at <b>6:55 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Zouheir Shama</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan. 10. 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Zouheir Shama, M.D.</b>						22d. ADDRESS <b>Prince George's Genl. Hosp. Cheverly, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1-15-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Not Harmony</b>				23d. LOCATION (City, town or county) (State) <b>Highland Park Md</b>			
24. FUNERAL DIRECTOR <b>H. S. Wash. + Son</b>						ADDRESS <b>4925 Seane Ave. N.E. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>Jan 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Carla Blomfield

Willie Thompson

Willie Thompson

Dec 2 1988

Jan 2

10-1988

Gravely, W. J.

Gravely, W. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01272

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01235

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Iowa b. COUNTY Polk			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b Des Moines, Iowa 53-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3009 Grand avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Gladys M. Stribling				4. DATE OF DEATH Month Day Year Jan 15, 19 66			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1887	
				9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (County & State, or foreign country) Dexter, Iowa	
						12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. Monroe				14. MOTHER'S MAIDEN NAME Laura May Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 478 12 2026		17. INFORMANT Betty S Kennedy		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Occlusion DUE TO (b) Atherosclerotic Hypert H. Des Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 10 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/18, 1965, to 1/15, 1966, that (I) (we) last saw the deceased alive on 1/16, 1966, and that death occurred at 11:00 M, from the causes and on the date stated above.							
22a. SIGNATURE [Signature] M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/15/66	
22c. PHYSICIAN'S NAME (Type) [Signature] M.D.				22d. ADDRESS 1801 Eye St NW Wash. DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Jan 15, 1966		23c. NAME OF CEMETERY OR CREMATORY Dunns Funeral Home		23d. LOCATION (City, town or county) (State) Des Moines Iowa	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 18 1966	
						25b. REGISTRAR'S SIGNATURE [Signature]	

Ernst Plaudner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01273 Item #7 Film #0373 2/1/66 DC											
11236											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>						c. LENGTH OF STAY IN ID <b>12 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						d. STREET ADDRESS <b>2022 20th St.</b>					
3. NAME OF DECEASED (Type or print) <b>MARIE</b> First Middle Last						4. DATE OF DEATH <b>JAN 9 1966</b> Month Day Year					
5. SEX <b>F</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5-30-31</b>		9. AGE (in years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coffee Packer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Mayson</b>						14. MOTHER'S MAIDEN NAME <b>Rebecca</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO <b>Central Vascular Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>10</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 28, 1965</b> to <b>Jan 9, 1966</b> that (I) (we) last saw the deceased alive on <b>Jan 9, 1966</b> and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William D. Rosson</b>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON</b>						22d. ADDRESS <b>5701 85th AVE HYATTSVILLE, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-13-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>				23d. LOCATION (City, town or county) (State) <b>Prince George's, Md.</b>	
24. FUNERAL DIRECTOR <b>Pharm Funeral Home</b>						ADDRESS <b>3015 12th Street, N. E.</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1966</b>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	

11-238

Washington, D.C.

22 days

1922 Nov 27

Prince George's General Hospital

Mable

Edward

1-23-22

Prince George's M.C.

Robert

John W. Jones

George's M.C. 1-23-22  
Prince George's M.C.  
1-23-22

Burial 1-23-22  
3012 12th Street, N.E.  
Harmony Memorial Pk.  
Prince George's M.C.  
1-23-22

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

012774

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01237

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>233 74th. Place</b>	
3. NAME OF DECEASED (Type or print) <b>Frank Sweeney</b>		4. DATE OF DEATH <b>1 5 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 April 1895</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR <b>1</b> Months <b>5</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DC Gen. Hosp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Sweeney</b>		14. MOTHER'S MAIDEN NAME <b>Bylinda Dyson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Same as Item #2</b>	
17. INFORMANT <b>Wife</b> Address <b>Mable O. Sweeney</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of cerebral artery</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-6-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 10-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros. 1661-Good Hope Rd SE Wash DC</b>		25a. REC'D BY REGISTRAR <b>JAN 10 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. C. Jones</b>			

11537

THE UNIVERSITY OF CHICAGO

11537

11537

FOR STATE  
HEALTH DEPT.

01275

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01238

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>Box 1236</b>	
3. NAME OF DECEASED (Type or print) <b>William Henry Thomas</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5-22-1900</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert R. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. King</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NUMBER <b>577-07-7932</b>	
17. INFORMANT <b>Mrs. Margaret Pessagno</b>		Address <b>5213- Carriage Dr. SE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardio vascular disease</b> DUE TO (c) <b>unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-10-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 13-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Simmons Bros. 1661- Good Hope Road S.E. Wash.</b>		25a. REC'D BY REGISTRAR <b>DC.</b> <b>JAN 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



14534



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01276					01239				
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 2 mos. 6 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park			16-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 4503 Knox Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle W. Last Thompson			4. DATE OF DEATH Month January Day 21 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-19-29		9. AGE (in years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal MACHINIST			10b. KIND OF BUSINESS OR INDUSTRY LITTON INDUSTRIES			11. BIRTHPLACE (County & State, or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ROBERT W. THOMPSON					14. MOTHER'S MAIDEN NAME HELEN DUNTON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES NOREAN			16. SOCIAL SECURITY NO. 578362837		17. INFORMANT HELEN D. THOMPSON Address: 4604 KNOX RD COLLEGE PK. MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578X Hepatic Coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Colon-Cutaneous fistula DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>the</del> (this hospital) attended the deceased from Nov. 15, 1965, to Jan. 21, 1966, that <del>the</del> (we) last saw the deceased alive on Jan. 21, 1966, and that death occurred at 2:15M, from the causes and on the date stated above.									
22a. SIGNATURE William D. Rosson M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/21/66		
22c. PHYSICIAN'S NAME (Type) William D. Rosson, M.D.					22d. ADDRESS 5701 85th Ave., Hyattsville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF Jan 25, 1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA.		
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md					25a. REC'D BY REGISTRAR DATE JAN 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

152 LA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

01277

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01240

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 mos. 3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> d. STREET ADDRESS <b>6464 Rollins Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>A</b> Last <b>Tippett</b>			4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 66</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-7-92</b>	9. AGE (In years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months <b>16</b> Days <b>- 1</b> Hours <b>16</b> Min. <b>16</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Walter Coombs</b>				
14. MOTHER'S MAIDEN NAME <b>Mittie F.</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				
16. SOCIAL SECURITY NO. <b>No</b>			17. INFORMANT <b>Eva Kiefer 6464 Rollins Ave. S. E.</b>				
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Chronic Pyelonephritis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Cardiovascular Disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (we) (this hospital) attended the deceased from <b>Oct. 11</b> , 19 <b>65</b> , to <b>Jan. 14</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>Jan. 14</b> , 19 <b>66</b> , and that death occurred at <b>1:50M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William D. Rosson</b>				22b. DATE SIGNED <b>Jan. 14, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>William D. Rosson, M.D.</b>				22d. ADDRESS <b>5701 85th Ave. Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			
23d. LOCATION (City, town or county) <b>Bladensburg, Md.</b>		(State)		24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b>			
25a. REC'D BY REGISTRAR <b>JAN 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

01240

01271

D. C.

Prince George's

Washington, D. C.

James J. Davis

University

and rolling Avenue

Prince George's General Hospital

1905

January

Times

A

Number

18

8-10-05

White

Female

James J. Davis

William D. Mason, M.D.

1501 22nd Ave. Haverhill, Ma.

1905

Jan. 1

1905

Jan. 1

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01279

01242

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>2114 Jameson Street</b>	
3. NAME OF DECEASED (Type or print) <b>Elsie Gladys Hayes Tonker</b>		4. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 March 1909</b>
9. AGE (In years lost birthday) yrs. <b>56</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, DC.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Davis Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Julie Michele Morel - 6217- Lumar DR. SE</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>981X IMMEDIATE CAUSE (a) Gun shot wound of brain</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by assailant</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>11:30 a.m. 1-8- 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-10-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 12th 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25a. REC'D BY REGISTRAR <b>JAN 13 1966</b>	
ADDRESS <b>Simmons Bros. 1661- Good Hope Rd. SE. Wash. DC</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

11515

11515



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01280

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01241

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 hr. 15 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>7707 Prospect Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank Thomas Tonker</b>		4. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 May 1909</b>
9. AGE (In years lost birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Room Foreman</b>		12. KIND OF BUSINESS OR INDUSTRY <b>P.E.P. Co. D.C.</b>	
13. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. FATHER'S NAME <b>UNKNOWN</b>		16. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
19. INFORMANT <b>NANCY M. TEAGUE</b>		20. Address <b>44-13 RIDGE ROAD GREENBELT, MARYLAND</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>976 X</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Shot self in head with a .25 caliber revolver.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:30 a.m.</b> 1-8- 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2114 Jameson Street, Hillcrest Heights, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kenoe</b> EXAMINER'S NAME (Type) <b>John Kenoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>1-10-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>13 JAN 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG, MARYLAND.</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co Riverdale, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JAN 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

11341

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01278		01243									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS 2305 Belair Drive					
3. NAME OF DECEASED (Type or print) Bradley Wayne Torene			4. DATE OF DEATH Month 1 Day 29 Year 1966			5. SEX M			6. COLOR OR RACE W		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 1 Nov., 1965			9. AGE (In years last birthday) yrs. 2 Months 29 Days			10. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY U. S.				13. FATHER'S NAME Robert Torene				14. MOTHER'S MAIDEN NAME Dina Koplowitz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address Robert Torene 2305 Belair Dr., Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X Bronchopneumonia										INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)				DATE SIGNED 1-31-66			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/4/66		22c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		22d. LOCATION (City, town, or county) Falls Church, Va. (State)			
23. FUNERAL DIRECTOR ADDRESS BERNARD DANZANSKY & SONS 3501 14th St.						24a. REC'D BY REGISTRAR FEB 7 1966		24b. REGISTRAR'S SIGNATURE Charles Judge			

STATE OF TEXAS  
COUNTY OF DALLAS  
CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Manner of death: [illegible]  
10. Signature of physician: [illegible]  
11. Signature of registrar: [illegible]  
12. Date of registration: [illegible]

13. Name of informant: [illegible]  
14. Relationship to deceased: [illegible]  
15. Date of information: [illegible]  
16. Signature of informant: [illegible]  
17. Signature of registrar: [illegible]  
18. Date of registration: [illegible]  
19. Signature of registrar: [illegible]  
20. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01281

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01244

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>4002 Colburne Road</b>	
3. NAME OF DECEASED (Type or print) <b>Hugh Torrence</b>		4. DATE OF DEATH <b>1 27 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1915</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Davidson, N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Cecelia Torrence</b>		Address <b>4002 Colburne Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b> DUE TO <b>From right hydro thorax</b> (b) <b>From acute pulmonary edema</b> DUE TO <b>From hypertensive heart disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>unknown</b> <b>unknown</b> <b>unknown</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-28-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 1, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>1727 N. Monroe Street</b>		DATE <b>FEB 2 1966</b>	

4251a

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <div style="text-align: center;">Prince George's</div> <div style="text-align: center;">MARYLAND</div>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <div style="text-align: center;">Washington, D.C.</div> b. COUNTY <div style="text-align: center;">47-3</div>							
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Cheverly</div>				<b>c. LENGTH OF STAY IN 1b</b> <div style="text-align: center;">6 days</div>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Washington, D.C.</div>							
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <div style="text-align: center;">Prince George's General Hospital</div>						<b>d. STREET ADDRESS</b> <div style="text-align: center;">1352 W. Street, S.E.</div>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center;">David S. Trimble</div>			<b>4. DATE OF DEATH</b> Month <div style="text-align: center;">January</div> Day <div style="text-align: center;">13</div> Year <div style="text-align: center;">19 66</div>										
<b>5. SEX</b> <div style="text-align: center;">Male</div>		<b>6. COLOR OR RACE</b> <div style="text-align: center;">White</div>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <div style="text-align: center;">8-24-77</div>		<b>9. AGE</b> (In years last birthday) <div style="text-align: center;">88 yrs.</div>		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Retired</div>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center;">Theater</div>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <div style="text-align: center;">Pa.</div>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="text-align: center;">USA</div>			
<b>13. FATHER'S NAME</b> <div style="text-align: center;">John A. Trimble</div>						<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center;"><del>Ellen</del> Ellen Marnell</div>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <div style="text-align: center;">Mrs. Agnes W. Brill- Niece-</div>				<b>Address</b> <div style="text-align: center;">Wash., DC 1352 W. St. SE</div>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <div style="text-align: center;">MYOCARDIAL INFARCTION</div> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <div style="text-align: center;">4201 DUE TO ARTERIOSCLEROTIC HEART DISEASE</div> <b>DUE TO (b)</b> <div style="text-align: center;">20 yrs</div> <b>DUE TO (c)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <div style="text-align: center;">1 HR</div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <div style="text-align: center;">19</div>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <div style="text-align: center;">Dec</div> , 1964, to <div style="text-align: center;">1/13</div> , 1966, that (I) (we) last saw the deceased alive on <div style="text-align: center;">1/12</div> 1966, and that death occurred at <div style="text-align: center;">6:54 AM</div> , from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <div style="text-align: center;">Leo H. Mugmon</div>						<b>M.D. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MEO. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <div style="text-align: center;">1/13/66</div>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <div style="text-align: center;">Dr. Leo H. Mugmon</div>						<b>22d. ADDRESS</b> <div style="text-align: center;">2711 GAITHER ST HILLCREE HIGHT</div>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <div style="text-align: center;">Burial</div>		<b>23b. DATE THEREOF</b> <div style="text-align: center;">Jan. 15th 66</div>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center;">St. Joseph's Cemetery</div>				<b>23d. LOCATION (City, town or county)</b> (State) <div style="text-align: center;">Connellsville, Pa.</div>					
<b>24. FUNERAL DIRECTOR</b> <div style="text-align: center;">Simmons Bros 1661 Good Hope Rd. S.E. Wash.</div>						<b>25a. REC'D BY REGISTRAR</b> <div style="text-align: center;">JAN 17 1966</div>		<b>25b. REGISTRAR'S SIGNATURE</b> <div style="text-align: center;">Charles Judge</div>					



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• *Approved*

## 2.1. Notation

Page of Report: 2 (General Section)

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• *Life*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01283					01246									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Prince George					a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>xx</del> <del>xx</del> <del>xx</del> Bradbury Pk, Md					b. COUNTY Prince George									
c. LENGTH OF STAY IN 1b <del>xx</del> <del>xx</del> <del>xx</del>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park, Md.									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4643 Lamar <del>Street</del> Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Fred Middle H. Last Uber					4. DATE OF DEATH Month 1 Day 7 Year 1966									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-1878		9. AGE (In years last birthday) 87 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal		11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME Samuel <del>Ruber</del> Uber					14. MOTHER'S MAIDEN NAME Augusta Senkin									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT Address Edna Brooks -daughter Same as 2d				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from Dec 27, 1965, to Jan 7, 1966, that (I) (we) last saw the deceased alive on Jan 3, 1966, and that death occurred at 12:30 M, from the causes and on the date stated above.														
22a. SIGNATURE John F. Shay					22b. DATE SIGNED 1-7-66									
22c. PHYSICIAN'S NAME (Type) JOHN F. SHAY					22d. ADDRESS 5203 Silver Hill Rd, Wash DC, 20028									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 Jan. 66		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		23d. LOCATION (City, town or county) (State) Washington, D.C.								
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash, D.C.					25a. REC'D BY REGISTRAR DATE JAN 13 1966									
					25b. REGISTRAR'S SIGNATURE J Charles Judge									

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01284 CERTIFICATE OF DEATH 01247											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>601 61st Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Bertha Mae Veringo</b>					4. DATE OF DEATH Month <b>Jan</b> Day <b>2</b> Year <b>19 66</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/9/22</b>		9. AGE (In years last birthday) <b>43</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME <b>Emory Fitzgerald</b>					14. MOTHER'S MAIDEN NAME <b>Katie Florence Perkins</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Veringo</b> Address <b>Same as #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coma, Severe Acidosis</b> <b>171X</b> DUE TO (b) <b>Renal obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Carcinoma of Cervix</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from <b>Dec. 12, 1965</b> , to <b>January 2, 1966</b> , that (we) last saw the deceased alive on <b>January 2, 1966</b> , and that death occurred at <b>6:20 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Wm J Greco</b>					22b. DATE SIGNED <b>1/3/66</b>		22c. PHYSICIAN'S NAME (Type) <b>William R. Greco, M.D.</b>				
22d. ADDRESS <b>6201 Riverdale Road., Riverdale, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/6/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>				
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons</b>					25a. REC'D BY REGISTRAR <b>Washing, D. C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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STATE OF DEATH

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		e. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deanwood Park		d. STREET ADDRESS 1508 Nye St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Andrew Wade		4. DATE OF DEATH Month 1 Day 31 Year 19 66		5. SEX M		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6 April, 1901		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. Govt		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Richard Otis Wade				14. MOTHER'S MAIDEN NAME Elizabeth Storried			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-46-7359		17. INFORMANT Eda T. Spriggs		Address 5108 1/2 Vash St. N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH Minutes over 2 yrs.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		DATE SIGNED 1-31-66		Address (Street, city, town, or county) Highland Park Md		(State) Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-66		22c. NAME OF CEMETERY OR CREMATORY Nat. Harmony		22d. LOCATION (City, town, or county) Highland Park Md	
23. FUNERAL DIRECTOR H.S. Washington		ADDRESS 4925 Deane Ave D.C.		24a. REC'D BY REGISTRAR FEB 7 1966		24b. REGISTRAR'S SIGNATURE James Judge	



RECEIVED CIVIL DEPT

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
John Doe		35		Male		White		10/10/1918		10:00 AM		Home		Heart Disease		Natural		John Doe		John Doe		John Doe	
Occupation		Residence		Marital Status		Education		Previous Illnesses		Previous Injuries		Previous Operations		Previous Deaths		Previous Dispositions		Previous Dispositions		Previous Dispositions		Previous Dispositions	
Teacher		123 Main St		Married		High School		None		None		None		None		None		None		None		None	
Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner		Signature of Coroner	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01286						01249					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Prince Georges						a. STATE Md.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						b. COUNTY PG					
c. LENGTH OF STAY IN ID 26 days						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General						d. STREET ADDRESS 5451 Newton Street					
3. NAME OF DECEASED (Type or print) Georgia V. Watson						4. DATE OF DEATH 1 12 19 66					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/3/82		9. AGE (In years last birthday) 84		10. IF UNOER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Money						14. MOTHER'S MAIDEN NAME Fanny Todd					
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Bernice Hutchinson- 2216-Norbeck					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-17, 1965, to 1-12, 1966, that (I) (we) last saw the deceased alive on 1-12, 1966, and that death occurred at 11:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE A. Reetz						22b. DATE SIGNED 1-13-66					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 1/15/66		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory				23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR				24a. ADDRESS		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Home Inc.				Nalley's Funeral		Mt. Rainier				J. Charles Judge	
Maryland				JAN 17 1966							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01287					01250						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Prince Georges</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5519 Nicholson Street 16-1</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>					d. STREET ADDRESS <b>East Riverdale, Md.</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First <b>SARAH</b> Middle <b>JANE</b> Last <b>WEBSTER</b>			4. DATE OF DEATH			Month <b>January</b> Day <b>31</b> Year <b>1966</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 4, 1878</b>		9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR: Months <b>31</b> Days <b>16</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Jerry A. Walker</b>					14. MOTHER'S MAIDEN NAME <b>Julia Allen</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Clarence Webster, Roanoke, Va.</b>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 weeks</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1962</b> to <b>1-31, 1966</b> , that (I) (we) last saw the deceased alive on <b>1-16, 1966</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Donald C. Edgren</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>Jan. 31, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN, M.D.</b>					22d. ADDRESS <b>4009 Gallatin St., Hyattsville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Roanoke, Virginia</b>			
24. FUNERAL DIRECTOR ADDRESS <b>W. W. CHAMBERS CO., Riverdale, Md.</b>					25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

058111

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01288

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01251

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Cedarville Traylor Park</b>	
3. NAME OF DECEASED (Type or print) <b>Roland</b>		4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W.</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <b>18 Sept 1916</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>IRW Systems</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Garrett William Welch</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>527-03-5807</b>	
17. INFORMANT <b>Miss Leora Welch</b>		Address <b>1808 N. Quinn St. Arlington, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contusion of brain stem</b> DUE TO (b) <b>816.6</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in head on collision.</b>	
20c. TIME OF INJURY Month, Day, Year <b>66</b> Hour <b>9:30</b> p.m. <b>1</b> <b>13</b> <b>30</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cedarville Rd.</b>		20f. (City or town) (County) (State) <b>Townsend, P.G., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>1-26-66/66</b>	
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		23b. DATE THEREOF <b>1/26/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Inglewood Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Inglewood, California</b>	
24. FUNERAL DIRECTOR <b>Ben C. Royce</b>		25a. REC'D BY REGISTRAR <b>IAN 28 1956</b>	
24b. ADDRESS <b>2847 Wilson Blvd. Arlington, Virginia</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>	

12514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
101289 CERTIFICATE OF DEATH 101252											
Items #7 & 8 from #G372 1/18/66 pc											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS 1115 56th Ave.					
3. NAME OF DECEASED (Type or print) First Middle Last William T. Wells						4. DATE OF DEATH Month Day Year Jan 9 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1900		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer				11b. KIND OF BUSINESS OR INDUSTRY Ambassador Hotel				11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry E. Wells						14. MOTHER'S MAIDEN NAME Georgetta Peters					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Edna M. Wells		Address 1115 56th Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Cardiac Respiratory Failure DUE TO (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pulmonary Edema										INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/9, 1966 to 1/9, 1966, that (I) (we) last saw the deceased alive on 1/9 1966, and that death occurred at 11 PM, from the causes and on the date stated above.											
22a. SIGNATURE Max M. Herzberg						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan. 10, 1966			
22c. PHYSICIAN'S NAME (Type) Max M. Herzberg, M.D.						22d. ADDRESS 7016 Greig St. Seat Pleasant, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-13-66		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town or county) (State) Suitland Maryland			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home						ADDRESS 4308 Suitland Md		25a. REC'D BY REGISTRAR JAN 14 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01290 <b>CERTIFICATE OF DEATH</b> 01253											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>				16-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>						d. STREET ADDRESS <b>4728 Homer Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHRISTA RENE</b>			First <b>Middle</b> <b>Last</b>			4. DATE OF DEATH <b>JANUARY 8 19 66</b>			Month <b>Day</b> <b>Year</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 JAN 66</b>		9. AGE (In years last birthday) <b>yrs.</b>		IF UNDER 1 YEAR Months <b>Days</b> <b>Hours</b> <b>Min.</b> <b>13 56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>RONALD HENRY WHEELER</b>						14. MOTHER'S MAIDEN NAME <b>LINDA MAE SPROUSE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NA</b>		17. INFORMANT <b>Father</b>		Address <b>Same as # 2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Distress Syndrome</b> <b>7735</b> DUE TO (b) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>7 Jan</b> , 19 <b>66</b> , to <b>8 Jan</b> , 19 <b>66</b> , that (H) (we) last saw the deceased alive on <b>8 Jan</b> , 19 <b>66</b> , and that death occurred at <b>1:30 P.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Conner Moore</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8 Jan 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>CONNER MOORE</b>						22d. ADDRESS <b>Air Force Base Hospital, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>SUITLAND, MD</b>					
24. FUNERAL DIRECTOR <b>CHAMBERS FUNERAL HOME</b>				ADDRESS <b>517 HIGLEY SE WASH, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

6-160479

01533

01533

PRINCE GEORGE

ARMED AND DANGEROUS

US AIR FORCE HOSPITAL

CHIEF OF HOSPITAL

GEN

FORWARD HENRY

NO

NO

ALISA MAE PRINCE

DATE 11-1-53

ALISA MAE PRINCE

11-1-53

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01291						01254					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Prince George			Laurel			Md			Pr. George		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
801 Laureltan Apts Apt 201			801 Laureltan Apts Apt 201			Laurel			11-9		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			e. IS RESIDENCE ON A FARM?		
FRANK WHITE						January 6 1966			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct 8, 1900		65 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Trainer-canner				race horses				North Wales, Penna		USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
George M. White						Catherine ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT			
no								Margaret White - a phone			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction											
4201 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis											
(c) Arteriosclerosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
Diabetes											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 2-20, 1964, to 2-15, 1965, that (I) (we) last saw the deceased alive on 2-15, 1965, and that death occurred at 10 AM, from the causes and on the date stated above.											
22a. SIGNATURE								22b. DATE SIGNED			
Dolores B. Brien								1-6-66			
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial				1-8-66		St Marys Cem		Laurel Md			
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR			
He Witt Danesdon								DATE JAN 11 1966			
								25b. REGISTRAR'S SIGNATURE			
								J Charles Judge			

01210

01210

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

REP

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01292					01255				
1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS 5806 42nd Ave.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) XXXXXX George Wesley			First Middle Last White		4. DATE OF DEATH Jan. 9 19 66		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-19-1887		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Mills		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New Brighton, Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Elmer White				14. MOTHER'S MAIDEN NAME Leulla Bourne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 174-01-4855		17. INFORMANT Isabella White same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Atherosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 18 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-6, 1966, to 1-9, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at 3:30 PM from the causes and on the date stated above.									
22a. SIGNATURE D. C. Edgren				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN	
22d. ADDRESS PRINCE GEO. PLAZA									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 1/12/66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR J. A. Hines Co				25a. REC'D BY REGISTRAR 2901-1424		25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. DATE JAN 12 1966	

01333

01333

RECEIVED 601110-0000



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01256

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Andrews Air Force Base Hospital</b>		d. STREET ADDRESS <b>5 Hillside Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Marie Myrtle White</b>		4. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>17 July 1895</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Trans Bldg</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry White</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Lucy Jenkins</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elaine W. Robinson</b> Address <b>72-15 Drexel Hill Penna</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>From laceration of brain</b> and fracture of left ankle and multiple fractures of left pelvis (c) <b>of left pelvis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by car.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>5:40pm</b> 1-9- 19 <b>66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Intersection of Silver Hill Rd. and Brooklyn Rd., Prince Geo. Co., Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-10-66</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-14-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1159

ASST. DIR. OF INVEST.

TO DIRECTOR

FROM

DATE

SUBJECT

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REFERENCE

NOTES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01294					01257					
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenn Dale Md.</i>			d. STREET ADDRESS <i>Box 118</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>90 Magnolia Gardens Nursing Home</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Rennell</i> Middle <i>Harford</i> Last <i>Willet</i>			4. DATE OF DEATH Month <i>January</i> Day <i>13</i> Year <i>1966</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 10 1879</i>		9. AGE (In years last birthday) <i>86</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Superintendent Railroad Co</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		
13. FATHER'S NAME <i>Rudolph F. Willett</i>					14. MOTHER'S MAIDEN NAME <i>Amelia Robey</i>					
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>216 10 2516</i>		17. INFORMANT <i>James Willett</i> Address <i>Glenn Dale Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial and Renal Failure</i> <i>593X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis</i> (c) <i>generalized atherosclerosis</i>								INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i> <i>years</i> <i>years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus. Senility.</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1/12</i> , 19 <i>66</i> , to <i>1/13</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/12</i> , 19 <i>66</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>H. James Kurtz</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Jan 13, 1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>H. James Kurtz</i>					22d. ADDRESS <i>R.F.D. Glenn Dale Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Jan 15, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St Paul's Episcopal</i>			23d. LOCATION (City, town or county) (State) <i>Waldorf Md.</i>		
24. FUNERAL DIRECTOR <i>F. Haack's Sons</i>					ADDRESS <i>4739 Balt. Ave Hyattsville Md</i>		25a. REC'D BY REGISTRAR <i>Jan 17 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

11507

11507

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]*

5-1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01295  
01258  
MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Suitland</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47-3	
c. LENGTH OF STAY IN 1b <i>3 Months</i>		d. STREET ADDRESS <i>1347 "G" St., S.E.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suitland Nursing Home, Inc.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Etta Williams</i>		4. DATE OF DEATH Month <i>January</i> 13, 19 <i>66</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/18/74</i>
9. AGE (in years last birthday) <i>91</i> yrs.		10. IF UNDER 1 YEAR Months <i>13</i> Days <i>19</i> Hours <i>66</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Fairfax Co., Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Jones</i>		14. MOTHER'S MAIDEN NAME <i>Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Albert Over</i>		Address <i>1347 "G" St., S.E. Washington, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> <i>334 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jul</i> , 19 <i>64</i> , to <i>1-13</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1-10</i> , 19 <i>66</i> , and that death occurred at <i>10:00 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>John J. Raedy</i>		22b. DATE SIGNED <i>1/13/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>John J. Raedy, M.D.</i>		22d. ADDRESS <i>2904 Nichols Ave., S.E., Wash., D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1.17.66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>Lee Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>300.4th st N E</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JAN 19 1966</i>			

E3S 16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. <sup>74</sup> ~~Page~~ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01296					01259				
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berwyn d. STREET ADDRESS 5619 Pautan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Schroeder Wilson			4. DATE OF DEATH Month Day Year January 10 19 66		5. SEX Male			6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-07		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Cab Driver		11. BIRTHPLACE (County & State, or foreign country) Wash, D.C.			12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles <del>Schroeder</del> Wilson					14. MOTHER'S MAIDEN NAME Rose Schaffer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Jessie Wilson			Address Same as #n2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMATEMESIS</u> 157X DUE TO <u>METASTATIC CARCINOMA OF PANCREAS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1-2 DAYS 7 MOS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>Dec. 27</u> , 1965, to <u>Jan. 10</u> , 1966, that (1) (we) last saw the deceased alive on <u>Jan. 10</u> , 1966, and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE Henry R. Wolfe					22b. DATE SIGNED 11/10/66			22c. PHYSICIAN'S NAME (Type) Henry R. Wolfe	
22d. ADDRESS 905 Sheridan St. Hyattsville, Maryland					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/13/1966		23c. NAME OF CEMETERY OR CREMATORY Arlington			23d. LOCATION (City, town or county) (State) Folk Mills, Va	
24. FUNERAL DIRECTOR Robert Mattingly			25a. ADDRESS Wash, D.C.		25b. REC'D BY REGISTRAR JAN 13 1966		25c. REGISTRAR'S SIGNATURE Charles Judge		



01859

Prince George's General Hospital

Prince George's General Hospital

White  
9-8-57  
Winson  
25

W. A. R.

James Wilson

HEMATEMESIS  
METASTATIC CARCINOMA OF UNKNOWN ORIGIN

X

Dec. 27 1957  
Henry R. Wolf  
305 Broadway St. New York 10014

Dr. H. R. Wolf  
305 Broadway St. New York 10014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01297											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 hrs. 58 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b> d. STREET ADDRESS <b>6259 Marlboro Pike</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Baby</b>			First <b>Boy</b>			Middle <b>Winters</b>			Last <b>Winters</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 13, 1966</b>		9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR <b>13</b> Months <b>19</b> Days <b>66</b> Years	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ernest Winter</b>						14. MOTHER'S MAIDEN NAME <b>Sandra Brooke</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>--</b>			Address <b>--</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immature Birth</b> 7625 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Atelectasis (Bilateral)</b> DUE TO (c) <b>--</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 13</b> , 1966, to <b>Jan. 13</b> , 1966, that <del>he</del> (we) last saw the deceased alive on <b>Jan. 13</b> , 1966, and that death occurred at <b>2:35 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Leroy E. Hoeck</b>								22b. DATE SIGNED <b>1-14-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Leroy E. Hoeck</b>	
22d. ADDRESS <b>Hillcrest Heights 3611 Branch Ave., S.E. Washington, D.C.</b>								22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				23b. DATE THEREOF <b>1/22/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hosp.</b>			23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>		
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr.</b>						24a. REC'D BY REGISTRAR <b>1 JAN 25 1966</b>			24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
6-148336											

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b> d. STREET ADDRESS <b>28 SWANN ROAD APT 203</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ERIC</b>		First <b>TIMOTHY</b>		Middle <b>WOOD</b>		Last <b>WOOD</b>		4. DATE OF DEATH <b>JANUARY 27 1966</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 JAN 66</b>		9. AGE (In years last birthday) <b>2</b> yrs. IF UNDER 1 YEAR: Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGE'S MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>MICHAEL BARRY WOOD</b>				14. MOTHER'S MAIDEN NAME <b>GLORIA OBIDOS DEL CASTILLO</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Father</b>		Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vertebral Hemorrhage of the brain</b> <b>5605</b> DUE TO (b) <b>Anoxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Foramen of Bachdale's Hernia</b> DUE TO (c) <b>Foramen of Bachdale's Hernia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>41 hrs-</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 25</b> , 19 <b>66</b> , to <b>JAN 27</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>27 JAN</b> 19 <b>66</b> , and that death occurred at <b>1230P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Richard D. Hasz</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>27 JAN 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD D. HASZ CAPT, USAF, MC</b>				22d. ADDRESS <b>USAF HOSP ANDREWS, ANDREWS AFB, WASH, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/25/66</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>PUBLIC CREMATION</b>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <b>Carl J. Campbell</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>5 FEB 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

6-162709

112580

CERTIFICATE OF DEATH

PUBLIC CREMATION

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY in 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>Laurel Bowie Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Harry Wootten</u>			<b>4. DATE OF DEATH</b> Last <u>1</u> Month <u>30</u> Day <u>19</u> Year <u>66</u>			<b>5. SEX</b> <u>M</u>			<b>6. COLOR OR RACE</b> <u>W</u>		
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>29 Jan., 1912</u>			<b>9. AGE</b> (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>carpenter</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>general construction</u>					
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Laurel Md</u>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>William M. Wootten</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Blanche R. Clark</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>1944-46</u>						<b>16. SOCIAL SECURITY NO.</b> <u>1944-46</u>					
<b>17. INFORMANT</b> <u>James W. Wootten, Beltsville, Md</u>						<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <u>  </u>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>						<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>					
<b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>						<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>John Kehoe</u> <b>M.D., Riverdale</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>EXAMINER'S NAME</b> (Type) <u>John Kehoe, M.D., Riverdale</u>						<b>DATE SIGNED</b> <u>1-31-66</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>						<b>22b. DATE THEREOF</b> <u>2-3-66</u>					
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Natl. Cem</u>						<b>22d. LOCATION</b> (City, town, or county) <u>Arlington, Virginia</u> <b>(State)</b> <u>  </u>					
<b>23. FUNERAL DIRECTOR</b> <u>DeWitt Donahoe</u> <b>ADDRESS</b> <u>Laurel Md</u>						<b>24a. REC'D BY REGISTRAR</b> <u>FEB 14 1966</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles J. J...</u>					



00750

EXAMINER'S REPORT

01308

01308

PATIENT INFORMATION		EXAMINER INFORMATION	
NAME	DATE OF BIRTH	NAME	DATE OF EXAMINATION
JOHN J. SMITH	10/15/1925	DR. J. H. BROWN	10/20/1950
ADDRESS		ADDRESS	
123 MAIN ST.		456 E. 10TH AVE.	
CITY		CITY	
ST. LOUIS, MO.		ST. LOUIS, MO.	
STATE		STATE	
MO.		MO.	
ZIP		ZIP	
63101		63101	
OCCUPATION		OCCUPATION	
ENGINEER		PHYSICIAN	
EDUCATION		EDUCATION	
B.S. MECHANICAL ENGINEERING		M.D. UNIVERSITY OF MISSOURI	
HIGHER DEGREE		HIGHER DEGREE	
NONE		NONE	
MARITAL STATUS		MARITAL STATUS	
MARRIED		MARRIED	
SPOUSE		SPOUSE	
JANE D. SMITH		JANE D. BROWN	
CHILDREN		CHILDREN	
3		2	
RELIGION		RELIGION	
CATHOLIC		CATHOLIC	
RACE		RACE	
WHITE		WHITE	
ETHNICITY		ETHNICITY	
IRISH		IRISH	
MILITARY SERVICE		MILITARY SERVICE	
NONE		NONE	
REASON FOR EXAMINATION		REASON FOR EXAMINATION	
ANNUAL PHYSICAL		ANNUAL PHYSICAL	
SYMPTOMS		SYMPTOMS	
NONE		NONE	
MEDICATION		MEDICATION	
NONE		NONE	
ALLERGIES		ALLERGIES	
NONE		NONE	
DIET		DIET	
NORMAL		NORMAL	
EXERCISE		EXERCISE	
NORMAL		NORMAL	
STRESS		STRESS	
NORMAL		NORMAL	
SLEEP		SLEEP	
NORMAL		NORMAL	
MENTAL STATUS		MENTAL STATUS	
NORMAL		NORMAL	
MOOD		MOOD	
NORMAL		NORMAL	
ANXIETY		ANXIETY	
NONE		NONE	
DEPRESSION		DEPRESSION	
NONE		NONE	
SUBSTANCE USE		SUBSTANCE USE	
NONE		NONE	
Tobacco		Tobacco	
NONE		NONE	
Alcohol		Alcohol	
NONE		NONE	
Drugs		Drugs	
NONE		NONE	
Other		Other	
NONE		NONE	
Family History		Family History	
NONE		NONE	
Personal History		Personal History	
NONE		NONE	
Social History		Social History	
NONE		NONE	
Sexual History		Sexual History	
NONE		NONE	
Reproductive History		Reproductive History	
NONE		NONE	
Gynecological History		Gynecological History	
NONE		NONE	
Urological History		Urological History	
NONE		NONE	
Endocrine History		Endocrine History	
NONE		NONE	
Immunological History		Immunological History	
NONE		NONE	
Neurological History		Neurological History	
NONE		NONE	
Cardiovascular History		Cardiovascular History	
NONE		NONE	
Respiratory History		Respiratory History	
NONE		NONE	
Gastrointestinal History		Gastrointestinal History	
NONE		NONE	
Genitourinary History		Genitourinary History	
NONE		NONE	
Musculoskeletal History		Musculoskeletal History	
NONE		NONE	
Dermatological History		Dermatological History	
NONE		NONE	
Ophthalmological History		Ophthalmological History	
NONE		NONE	
Otolaryngological History		Otolaryngological History	
NONE		NONE	
ENT History		ENT History	
NONE		NONE	
Neurological Examination		Neurological Examination	
Normal		Normal	
Cardiovascular Examination		Cardiovascular Examination	
Normal		Normal	
Respiratory Examination		Respiratory Examination	
Normal		Normal	
Gastrointestinal Examination		Gastrointestinal Examination	
Normal		Normal	
Genitourinary Examination		Genitourinary Examination	
Normal		Normal	
Musculoskeletal Examination		Musculoskeletal Examination	
Normal		Normal	
Dermatological Examination		Dermatological Examination	
Normal		Normal	
Ophthalmological Examination		Ophthalmological Examination	
Normal		Normal	
Otolaryngological Examination		Otolaryngological Examination	
Normal		Normal	
ENT Examination		ENT Examination	
Normal		Normal	
Laboratory Tests		Laboratory Tests	
Normal		Normal	
X-rays		X-rays	
Normal		Normal	
Special Studies		Special Studies	
Normal		Normal	
Diagnosis		Diagnosis	
None		None	
Recommendations		Recommendations	
None		None	
Follow-up		Follow-up	
None		None	
Comments		Comments	
None		None	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01299

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01261

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1939</u>	
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>28</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Prince Geo's Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leo Willie Young</u>				14. MOTHER'S MAIEN NAME <u>Carrie Hawkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>217-34-0470</u>		17. INFORMANT <u>Mrs. Anna L. Young</u> Address <u>1086 Marlboro Pike Upper Marlboro, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8234 Laceration of brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Trauma - auto accident</u> (c) <u>4 days</u> PART II. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car which struck pole.</u> 20c. TIME OF INJURY Month, Day, Year <u>8:30 P.M. 27 Jan. 1966</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 408 near Brown Station Rd. PG. Md.</u> 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address <u>Baltimore, Md.</u> 22. DATE SIGNED <u>2-1-66</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-5-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Brooks Meth. Church Cem. Croome Pr. Geo's. Md.</u> 23d. LOCATION (City or Town) (County) (State) 24. FUNERAL DIRECTOR <u>Marstell Adams</u> ADDRESS <u>Aquasco Md.</u> 25a. REC'D BY REGISTRAR <u>Feb 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

10510